pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **NORTHVIEW ESTATES LIMITED PARTNERSHIP**
LEGAL ENTITY

To operate **NORTHVIEW ESTATES**
NAME OF FACILITY OR AGENCY

Located at **945 BORDER AVENUE, ELLWOOD CITY, PA 16117**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **75**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 10**

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

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

and shall remain in effect from **May 29,** **2024** until **November 29,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **404991**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: May 29, 2024

[redacted]
Northview Estates Limited Partnership
[redacted]

RE: Northview Estates
945 Border Avenue
Ellwood City, PA 16117
License/COC #: 40499

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 30, 2023, December 1, 2023, and March 27, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (40499) dated December 24, 2023, to December 24, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 29, 2024 to November 29, 2024.

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

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
81(b)	II	55	$5	$275	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *NORTHVIEW ESTATES* **License #**: *40499* **License Expiration**: *12/24/2023*

Address: *945 BORDER AVENUE, ELLWOOD CITY, PA 16117*

County: *LAWRENCE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *NORTHVIEW ESTATES LIMITED PARTNERSHIP*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/10/2001* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *12/01/2023*

Inspection Dates and Department Representative

11/30/2023 - On-Site: [redacted]

12/01/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *59*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1ST FLOOR* **Capacity**: *10* **Residents Served**: *9*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *59*

Diagnosed with Mental Illness: *20* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *13* **Have Physical Disability**: *0*

Inspections / Reviews

11/30/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/01/2024*

01/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/19/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/24/2024*

02/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/19/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/19/2024*

05/17/2024 - Document Submission

Submitted By [redacted] **Date Submitted**: *02/19/2024*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 11/30/23 at approximately 9:40 a.m., the resident privacy coding document, including the name of resident #1, was attached to the licensing inspection summary (LIS), dated 9/12/23 & 9/13/23, posted on the bulletin board in the main entrance hallway of the home.

On 11/30/23 at 11:45 a.m., multiple resident records, including resident #2 and resident #3's bowel movement logs and scabies logs were unlocked, unattended, and accessible on top of the refrigerator in the Secure Dementia Care Unit.

Plan of Correction ***Accept[redacted] - 02/12/2024)***

1. The facility policy on Resident Charts was updated on 12/12/23 by the Administrator.
2. The facility policy on Resident Charts was reviewed by the Administrator with the Care Manager of the dementia unit and the Office Manager on 12/12/23.
3. Beginning 12/13/23 the Care Manager of the dementia unit will complete a Quality Management Checklist for the dementia unit daily when scheduled to verify resident records are only accessible by authorized individuals.
4. Beginning 1/3/24 the Office Manager will complete a Posting Requirement Report monthly to verify the licensing inspection summary does not include the resident privacy coding document.
5. Beginning 1/4/24 the Administrator will review the Quality Management Checklist SCU and the Posting Requirement Report monthly to verify completion.
6. The resident privacy coding document was removed from the bulletin board on 11/30/23 by the Administrator.
7. All resident records were in the Secured Dementia Unit were removed from the common area and place in a locked area during the inspection on 11/30/23 by the Care Manager and the Administrator.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Not Implemented[redacted] - 05/17/2024)

51 - Criminal Background Check

2. Requirements

2600.

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

Description of Violation

The home did not complete a criminal history background check on staff person A, hired on [redacted]/23.

Plan of Correction ***Accept[redacted] 02/12/2024)***

1. A criminal background check was completed for staff person A on [redacted]27/23.
2. The facility policy on Employee Files was updated by the Administrator on 12/28/23.
3. The facility policy on Employee Files was reviewed by the Administrator with the Human Resource Manager and the Office Assistant on 12/27/23.

51 - Criminal Background Check (continued)

4. Beginning 12/27/23 the Office Manager will ensure all new hires have Pennsylvania State Police criminal background check completed prior to working. Beginning 12/27/23 the Office Manager will document that the background check was completed on the New Employee Checklist.
5. Beginning 12/27/23 the Office Manager will complete Quality Management Checklist for employee records of all new hires each month.
6. Beginning 12/27/23 the Administrator will verify all new hires have had a PA State Police Criminal Background Check each month.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 05/17/2024)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 02/12/2024)***

1. As of 12/5/23 staff person B no longer works at the facility.
2. Staff person A is no longer is a direct care staff person.
2. The facility policy on Employee Files was updated by the Administrator on 12/27/23.
3. The facility policy on Employee Files was reviewed by the Administrator with the Human Resource Manager and the office manager and the Office Assistant on 12/27/23.
4. Beginning 12/27/23 the Office Manager will ensure all newly hired direct care staff persons have a high school diploma, GED or active registry on the PA Nurse Aid Registry. The Office Manager will document that the diploma, GED, or active nurse aide registry status is on file and will verify on the New Employee Checklist for every new hire upon being hired.
5. Beginning 12/27/23 the Office Manager will complete Quality Management Checklist for employee records of all new hires each month verifying the employee's diploma, GED or nurse aid registry status is maintained in their file.
6. Beginning December 2023, the Administrator will verify the Quality Management Checklist is completed and review monthly.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented [redacted] - 05/17/2024)

60a - Staff/Support Plan

4. Requirements

60a - Staff/Support Plan *(continued)*

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

Description of Violation

On 11/5/23, there were 59 residents in the home, 10 with mobility needs requiring assistance of 1 staff person to evacuate in an emergency, and 3 residents who require the assistance of 2 staff persons to evacuate in the event of an emergency. On this date, there were only 3 direct care staff persons working in the home to assist residents to evacuate in the event of an emergency from 10:30 p.m. to 6:00 a.m. on 11/6/23.

On 11/12/23, there were 59 residents in the home, 10 with mobility needs requiring assistance of 1 staff person to evacuate in an emergency, and 3 residents who require the assistance of 2 staff persons to evacuate in the event of an emergency. On this date, there were only 3 direct care staff persons working in the home to assist residents to evacuate in the event of an emergency from 10:30 p.m. to 6:00 a.m. on 11/13/23.

On 11/27/23, there were 60 residents in the home, 10 with mobility needs requiring assistance of 1 staff person to evacuate in an emergency, and 3 residents who require the assistance of 2 staff persons to evacuate in the event of an emergency. On this date, there were only 2 direct care staff persons working in the home to assist residents to evacuate in the event of an emergency from 10:30 p.m. to 6:00 a.m. on 11/28/23.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. On 12/31/23 an additional staff person was placed on the 10:30 to 6:00 a.m. shift.
2. On 12/30/23 the Care Manager of the dementia unit was added to the facility's alarm monitoring call list. The Care Manager lives next to the facility and will be notified of any fire alarm by the alarm monitoring company and will report to the facility to assist with evacuation of residents.
3. Two residents requiring the assistance of 2 staff persons were issued a 30 day notice on 1/2/24 and will be relocated to another facility by 1/31/24.
4. Effective immediately the administrator will ensure adequate staffing is provided to meet the needs of the residents as specified in the resident's support plan.
5. The facility Resident List was updated by the Administrator on 1/24/24 to include the resident census, immobile resident residents, level of assistance of residents and assistive devices utilized by each resident.
6. Beginning 1/25/24 the Resident List will be reviewed by the Administrator and or the Resident Care Coordinator daily to evaluate and ensure sufficient staff are schedule to meet the needs of the residents.
7. The facility policy on Resident Assessment - Support Plan RASP was updated on 1/24/24 by the Administrator and will be reviewed with all staff by 2/1/24 by the Administrator. Beginning 1/25/24 all Nurses, Care Managers and Med Techs will log any resident care changes as they occur on the RASP - Change in Care Summary. All staff to include the Administrator will review the RASP - Change in Care Summary at the beginning of their shift. The Resident Care Coordinator will update the RASP within 24 hours of reviewing the RASP - Change in Care Summary.

Licensee's Proposed Overall Completion Date: *01/25/2024*

Implemented ([redacted] - 05/17/2024)

65a - FS Orientation 1st Day

5. Requirements

2600.

65a - FS Orientation 1st Day *(continued)*

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, hired [redacted]/23, did not complete any of the initial trainings as specified in 65(a)(1)-(7).

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. Staff person A completed all trainings as specified in 65(a)(1)-(7) on 12/29/23.

2. The facility policy on Employee Files was updated by the Administrator on 12/28/23 to include that all original employee training records will be maintained in the Administrator's office.

3. The facility policy on Employee Files was reviewed by the Administrator with the Office Assistant on 12/29/29.

5. Beginning 1/22/23 the Administrator or Office Manager in the event the Administrator is unavailable will audit all new employee records on or prior to their first day of work to ensure all newly hired staff are trained on all areas specified in 65(a)(1)-(7).

6. Beginning 1/22/23 the Administrator will train all newly hired staff on all areas as specified in 65(a)(1)-(7).6. Beginning 1/22/23 the Administrator will train all newly hired staff on all areas as specified in 65(a)(1)-(7).

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented [redacted] - 05/17/2024)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, hired [redacted]/23, did not complete any of the initial trainings as specified in 65(b)(1)-(4) within 40 scheduled working hours.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. Staff person A completed all trainings as specified in 65b on 12/29/23.

2. The facility policy on Employee Files was updated by the Administrator on 12/28/23 to include that all original

65b - Rights/Abuse 40 Hours (continued)

employee training records will be maintained in the Administrator's office.
3. The facility policy on Employee Files was reviewed by the Administrator with the Office Assistant on 12/29/29.
4. Beginning 12/27/23 the Office Manager will complete Quality Management Checklist for employee records of all new hires each month.
5. Beginning 1/22/23 the Administrator or Office Manager in the event the Administrator is unavailable will audit all new employee records on or prior to their first day of work to ensure all newly hired staff are trained on all areas specified in 65(b)(1-4).
6. Beginning 1/22/23 the Administrator will train all newly hired staff on all areas as specified in 65(b)(1-4).

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented [redacted] - 05/17/2024)

81b - Resident Personal Equipment

7. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 11/30/23 at 11:00 a.m., the U-shaped enabler bar attached to resident #6's bed was not securely attached, and the center of the enabler bar was uncovered leaving an approximate 13 inches x 20 inches opening posing an entrapment risk.

Repeat Violation: 9/12/2022 et al

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. The facility policy on Assistive Device Safety Checklist was updated by the Administrator on 12/28/23 to include that resident personal equipment to include enabler bars will be checked daily by the midnight med tech.
2. The facility policy on Assistive Device Safety Checklist was reviewed by the Administrator with staff responsible for checking resident personal equipment on 12/29/23.
3. The Assistive Device Safey Checklist was updated on 12/15/23 by the office assistant. The office assistant will continue to ensure the checklist is updated as resident equipment changes.
4. All resident personal equipment has been inspected daily since 12/15/23 by the midnight med tech and is clean, in good repair and free of hazards.
5. Resident 6's enabler bar was removed on 11/30/23.
6. Beginning 12/27/23 the Assistive Device Safety Checklist will be reviewed monthly by the Administrator during the Quality Management meeting to ensure checks are being completed and checklist is updated properly.

Licensee's Proposed Overall Completion Date: *01/24/2024*

Not Implemented [redacted] - 05/17/2024)

82a - Poisonous Materials

8. Requirements

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

82a - Poisonous Materials *(continued)*

Description of Violation

On 11/30/23 at 10:15 a.m., a 500 ml spray bottle of Resolve Stain Remover Carpet Cleaner was unlocked, unattended, and accessible under the sink in the main dining room of the home. Multiple residents are not able to use or avoid poisons including resident #5.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. The bottle of Resolve was removed by the Administrator and placed in a locked storage area on 11/30/23.
2. The facility policy on Chemicals in the Workplace was updated by the Administrator on 12/12/23.
3. The facility policy on Chemicals in the Workplace was reviewed by the Administrator with staff responsible for their work areas on 12/14/23.
4. Beginning 12/15/23 designated staff will check all resident rooms weekly, the Kitchen Supervisor will check the food service area and dining areas and the SDU Care Manager will check all dementia unit common areas. These checks will be done daily during their scheduled shifts. Documentation that these areas have been checked for chemical will be maintained on the Resident Living Area Quality Management Checklist and the Facility Common Area Quality Management Checklist.
5. Beginning 12/27/23 the Administrator will verify monthly during the Quality Management Team meeting that both the Resident Living Area and Facility Common Area Quality Management checklists are completed.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented ([redacted] - 05/17/2024)

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

Resident #7's glucometer was used to measure resident #6's blood glucose levels on 11/2/23 at 11:55am.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1, Resident 7's glucometer was replaced on 12/25/23.
2. Resident 7's physician was notified on 12/1/23 that resident 7's glucometer was used on another resident.
3. All staff responsible for administering medication were training by the Administrator on 12/14/23 on the Violation and the facilities policies on Accu Checks and Medication Administration.
4. Disciplinary action was taken on the staff person responsible for utilizing resident 7's glucometer for resident 6 for failing to follow the facility's policy on Accu Checks and Medication Administration.
5. Beginning 1/1/24 the day turn nurse will check all resident glucometers weekly to ensure the correct glucometer is being used and readings are properly documented. Documentation will be maintained on the Blood Sugar and Insulin Administration Quality Assurance Log.
6. Beginning 12/27/23 the Administrator will verify monthly that all glucometers are being checked weekly during the monthly Quality Management Team meeting,
7. Resident #6's physician was notified on 1/22/24 that another resident's glucometer was used on his patient.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Not Implemented [redacted] - 05/17/2024)

85d - Trash Receptacles

10. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 11/30/23 at 12:00 p.m., a ¼ filled trash can in the shared bathroom of resident bedroom #107 did not have a lid.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. The office manager placed a trash can with a lid in room 107 on 12/1/23.
2. The facility policy on Waste Removal was reviewed by the Administrator with staff responsible for checking resident rooms in both the dementia unit and the main building on 12/12/23.
3. Beginning 12/15/23 the Housekeeper and the Care Manager of the dementia unit will check all resident rooms weekly to verify all resident shared bathrooms have a trash can with a lid. Documentation will be kept on the Resident Living Area Quality Management Checklist.
4. Beginning 12/27/23 the Administrator will verify monthly that all resident bathrooms are checked during the monthly Quality Management Team meeting.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Not Implemented ([redacted] - 05/17/2024)

85e - Trash Outside Home

11. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 11/30/23 at 9:00 a.m., 3 garbage bags of trash were observed next to the dumpster in the main parking lot of the home.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. Garbage bags were placed in the dumpster on 12/1/23 by the office manager.
2. The facility policy on Waster Removal was reviewed by the Administrator with staff responsible for checking the dumpster in both the dementia unit and the main building on 12/12/23.
3. Beginning 12/15/23 the Kitchen Supervisor will check the dumpster area during each of [redacted] shifts and to ensure the dumpster is closed and there is no garbage or trash outside of the dumpster. Documentation will be maintained on the Quality Management Checklist for Food Service.
4. Beginning 12/28/23 the Care Manager of the dementia unit will check the dumpster area during each of [redacted] shifts to ensure all dumpster doors/lids are shut and no trash is around the dumpster. Documentation will be kept on the Quality Management Checklist for the Secured Dementia Unit.
4. Beginning 12/27/23 the Administrator will verify monthly that Quality Management checklists for Food Service and SDU are completed during the monthly Quality Management Team meeting.

Licensee's Proposed Overall Completion Date: *01/22/2024*

85e - Trash Outside Home *(continued)*

Implemented (- 05/17/2024)

101j7 - Lighting/Operable Lamp

12. Requirements

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

Description of Violation

On 11/30/23 at 10:30 a.m., resident #5 did not have access to a source of light that could be turned on/off at bedside.

On 11/30/23 at 11:30 a.m., resident #2 did not have access to a source of light that could be turned on/off at bedside.

Plan of Correction ***Accept 02/12/2024)***

1. The maintenance an operable light source in room on 12/27/23.
2. The facility policy on Resident Living Areas was reviewed by the Administrator with staff responsible for checking resident rooms in both the dementia unit and the main building on 12/12/23.
3. Beginning 12/15/23 the Housekeeper and the Care Manager of the dementia unit will check all resident rooms weekly to verify all resident have a lighting source at their bedside. Documentation will be kept on the Resident Living Area Quality Management Checklist.
4. Beginning 12/27/23 the Administrator will verify monthly that all resident living areas are checked during the monthly Quality Management Team meeting.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented - 05/17/2024)

131f - Fire Extinguisher Inspection

13. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The home's fire suppression system fire extinguisher over the gas stove in the main kitchen was last inspected in August of 2022.

Plan of Correction ***Accept - 02/12/2024)***

1. The fire suppression system was upgraded and inspected on January 4, 2024 by Aven Fire Systems.
2. The facility Quality Management Checklist was updated by the Administrator on 12/29/23 to include the verifying all fire extinguishers and the fire suppression system is inspected annually,
3. Beginning 12/27/23 the Administrator will ensure that fire extinguishers and the fire suppression system is inspected annually.

Licensee's Proposed Overall Completion Date: *01/22/2024*

131f - Fire Extinguisher Inspection *(continued)*

Implemented [redacted] - 05/17/2024)

132b - Safety Inspection/Fire Drill

14. 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 safety inspection and fire drill conducted by a fire safety expert was completed on 9/14/22.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. A fire inspection and fire drill was conducted by the Ellwood City Fire Department on 12/18/23.
2. The facility Quality Management Checklist was updated by the Administrator on 12/29/23 to include the verification that the Ellwood City Fire Department will conduct a drill and inspect the fire system annually,
3. Beginning 12/29/23 the Administrator will review the Facility Quality Management Checklist monthly to ensure that a fire inspection and fire drill are conducted by a fire safety expert annually.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented [redacted] - 05/17/2024)

132c - Fire Drill Records

15. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 1/24/23 does not include a.m. or p.m.
The fire drill record for the drill conducted on 4/28/23 does not include the amount of time to evacuate.
The fire drill record for the drill conducted on 6/30/23 does not include a.m. or p.m.

Plan of Correction ***Accept [redacted] - 01/17/2024)***

1. The Administrator will conduct all fire drills effective December 2023.
2. A fire drill was conducted on December 15, 2023 by the Administrator.
3. The facility Quality Management Checklist was updated by the Administrator on 12/29/23 to include verification the fire drills are conducted monthly and properly logged.
4. The Administrator will ensure that fire drills are conducted monthly and properly logged effective December 2023.

Licensee's Proposed Overall Completion Date: *12/29/2023*

Implemented [redacted] - 05/17/2024)

132h - Designated Meeting Place

16. Requirements

2600.

132h - Designated Meeting Place *(continued)*

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the following fire drills, not all residents were evacuated to a designated meeting place away from the building or within the fire-safe area:
4/28/23 at 10:30am there were 50 residents in the home, however, only 20 residents were evacuated.
5/31/23 at 2:15pm there were 52 residents in the home, however, only 49 residents were evacuated.
6/30/23 at 12:00 there were 49 residents in the home, however, only 47 residents were evacuated.
7/27/23 at 4:43am there were 56 residents in the home, however, only 15 residents were evacuated.
8/15/23 at 4:51pm there were 55 residents in the home, however, only 52 residents were evacuated.
9/11/23 at 1:12pm there were 59 residents in home, however, only 56 residents were evacuated.
10/25/23 at 12:33pm there were 58 residents in home, however, only 55 residents were evacuated.
11/30/23 at 5:05pm, there were 58 residents in home, however, only 56 residents were evacuated.

Plan of Correction ***Accept[redacted] 02/12/2024)***

1. The Administrator will conduct all fire drills effective December 2023.
2. On 1/22/23 the Administrator updated the Admissions Agreement to include additional information on resident participation fire drills and instructions on evacuating the facility during a fire alarm. This information will be reviewed with all new residents upon admission.
3. On 1/23/23 the Administrator reviewed Resident Evacuation Protocols with all residents during which resident were shown where they will evacuate to in the event of a dire alarm. Evacuation Protocols will be reviewed by the Administrator with all residents by 1/25/24.
4. On December 14, 2023 all staff were trained by the Administrator on fire safety and the facility's emergency preparedness plan to include the requirement that all residents shall evacuate to a designated meeting place or within a fire safe area during each drill.
5. A fire drill was conducted on December 15, 2023 by the Administrator and on December 18, 2023 by the Ellwood City Fire Department. All residents were evacuated to a fire safe area during each drill.
6. The facility Quality Management Checklist was updated by the Administrator on 12/29/23 to include verification the fire drills are conducted monthly and properly logged.
7. The Administrator will ensure that fire drills are conducted monthly and properly logged and all residents are evacuated to a safe area effective December 2023.

Licensee's Proposed Overall Completion Date: *01/25/2024*

Implemented ([redacted] - 05/17/2024)

141a 1-10 Medical Evaluation Information

17. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #3's medical evaluation, dated [redacted] 1/23, did not include the resident's date of birth, temperature, body positioning or cognitive functioning. These sections of the form were blank.

Resident #5's medical evaluation, dated [redacted] /23, did not include the resident's weight, pulse rate, blood pressure or temperature. These sections of the form were blank.

Resident #6's medical evaluation, dated [redacted] 5/23, did not include the resident's heath status or cognitive functioning. These sections of the form were blank.

Plan of Correction ***Accept ([redacted] 02/12/2024)***

1. The resident care coordinator was verbally disciplined on 12/4/23 for failing to have a medical evaluation completed in accordance with the facility's policy on medical evaluations.

2. The resident care coordinator had resident 3, 5 and 6's medical evaluations updated on 12/4/23.

3. The office assistant and day turn nurse were trained on the facility's policy on Medical Evaluations by the Administrator on 12/27/23.

4. Beginning December 27, 2023. The office assistant will complete the Quality Management Checklist - Medical Evaluation by month for all residents and schedule appointments with resident's physicians one month prior to the due date of the medical evaluation.

5. Beginning 1/1/24 the day turn nurse will review all medical evaluations upon receipt, and document that the medical evaluation contains the resident's date of birth, temperature, body positioning/cognitive functioning, weight, pulse rate, blood pressure, temperature and health status. Documentation that all items are included on the medical evaluation will be kept on the Quality Management Checklist for Medical Evaluations.

6. Beginning 12/27/23 the Administrator will verify that the completion of the Quality Management Checklist for Medical Evaluations during the monthly Quality Management Team meeting.

7. Beginning 1/23/24 the Office Manager and day turn nurse will audit all resident medical evaluations completed in the past year. Beginning 1/23/24 the care manage in the dementia unit will audit all medical evaluations completed in the past year. Audits will be conducted to verify the initial medical evaluation is completed within 60 days prior to admission or 30 days after admission and also ensure all required information is accurate and complete. Missing or incomplete medical evaluations will immediately be returned to the physician for completion. All resident medical evaluations from the past year will be audited by 1/30/23.

Licensee's Proposed Overall Completion Date: *01/23/2024*

Implemented [redacted] - 05/17/2024)

141b1 - Annual Medical Evaluation

18. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 4's most recent medical evaluation was completed on [redacted]/23; however, the resident's previous medical evaluation was completed on 8/3/22.

Plan of Correction ***Accept ([redacted] - 02/12/2024)***

1. The resident care coordinator was verbally disciplined on 12/4/23 for failing to have a medical evaluation completed in accordance with the facility's policy on medical evaluations.
2. The office assistant and day turn nurse were trained on the facility's policy on Medical Evaluations by the Administrator on 12/27/23.
3. Beginning December 27, 2023 The office assistant will complete the Quality Management Checklist - Medical Evaluation by month for all residents and schedule appointments with resident's physicians one month prior to the due date of the medical evaluation.
4. Beginning 1/1/24 the day turn nurse will review all medical evaluations to ensure all medical evaluation are completed annually. Documentation that all medical evaluations are completed annually will be kept on the Quality Management Checklist for Medical Evaluations.
5. Beginning 1/1/24 the Administrator will verify that the completion of the Quality Management Checklist for Medical Evaluations during the monthly Quality Management Team meeting.
6. Beginning 1/23/24 the Office Manager and day turn nurse will audit all resident medical evaluation in the past year. Beginning 1/23/24 the care manage in the dementia unit will audit all medical evaluations completed in the past year. Missing or incomplete medical evaluations will immediately be returned to the physician for completion. All resident medical evaluations from the past year will be audited by 1/30/23.

Licensee's Proposed Overall Completion Date: *01/23/2024*

Implemented [redacted] - 05/17/2024)

183d - Prescription Current

19. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 11/30/23, the home's floor #1 and floor #2 medication carts contained 20, 5 ml syringes with Morphine Sulfate 100mg/5ml prescribed for resident #5-give 1 syringe under the tongue every hour as needed for pain of shortness of breath. However, the medication expired 5/22/23.

183d - Prescription Current *(continued)*

Plan of Correction ***Accept [redacted] - 01/17/2024)***

1. The Morphine Sulfate was discarded on 11/30/23 by nursing staff.
2. All staff responsible for administering medications were trained on 12/14/23 by the administrator on expired medications and the Monthly PRN Reconciliation Form.
3. Beginning 12/15/23 the midnight med tech will complete the Monthly PRN Reconciliation form. In doing so all resident PRN medications will be checked monthly by the midnight med tech to ensure no PRN medications have expired and that all PRN medications for residents are present.
4. Beginning 1/2/24 the administrator will verify monthly during the Monthly Quality Management Team meeting that the Monthly PRN Reconciliation Form is completed.

Licensee's Proposed Overall Completion Date: *01/02/2024*

Implemented [redacted] 05/17/2024)

187d - Follow Prescriber's Orders

20. Requirements

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

Description of Violation

Resident #6 is prescribed Novolog 100mg/unit vial - subcutaneous injection before meals and at bedtime per the following sliding scale:
70-130= 0
131-180- 2U
181-240= 4U
241-300= 6U
301-350= 8U
351-400= 10U
>400 = 12U call MD
However, on 11/5/23 and 11/11/23 at 7:30 a.m., the medication was not administered nor was the resident's blood glucose measured at this time.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. All staff responsible for administering medication were trained by the Administrator on 12/14/23 on the Violation and the facility's policies on Accu Checks and Medication Administration.
2. Disciplinary action was taken on 12/4/23 on the staff person responsible for failing to properly administer medication in accordance with the facility policy on medication administration and failing to properly report that the residents medication was not administered.
3. Beginning 1/1/24 the day turn nurse will check all resident glucometers weekly to ensure the correct glucometer is being used and readings are properly documented. Documentation will be maintained on the Blood Sugar and Insulin Administration Quality Assurance Log.
4. Beginning 12/27/23 the Administrator will verify monthly that all glucometers are being checked weekly during the monthly Quality Management Team meeting,

Licensee's Proposed Overall Completion Date: *01/22/2024*

Not Implemented [redacted] - 05/17/2024)

227d - Support Plan Medical/Dental

21. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #5 is currently receiving Hospice services, however, the resident's support plan dated 10/10/23 does not indicate this need or how this need will be met.

Resident #6 is currently using an enabler bar, however, the resident's support plan dated 6/9/23 does not indicate this need or how this need will be met.

Resident #7 is currently using an enabler bar, however, the resident's support plan dated 8/5/23 does not indicate this need or how this need will be met.

Plan of Correction ***Accept [redacted] - 01/17/2024)***

1. Resident 5's RASP was updated on 12/29/23 by the nurse to include the need for Hospice Services and how it will be met.
2. Resident 6's enabler bar was removed on 11/30/23 during the inspection.
3. Resident 7's RASP was update on 12/29/23 by the nurse to indicate the resident's need for an enabler bar.
4. On 12/29/23 the facility policy on RASP's, regulation 227 and the violation was reviewed by the Administrator with the med tech who will be completing the RASPs.
5. Beginning 1/1/24 the med tech completing the RASPs will complete a Quality Management Checklist - RASPs monthly verifying that the medical, dental, vision, hearing, mental health, behavioral care services, need for Hospice services and the use of enabler bars in indicated on the RASP.
6. Beginning 1/1/24 the Administrator will review all RASPs as indicated on the Quality Management Checklist - RASPs monthly to verify the medical, dental, vision, hearing, mental health, other behavioral care service, enabler bars and Hospice service are indicated on the RASP.

Licensee's Proposed Overall Completion Date: *12/29/2023*

Implemented [redacted] - 05/17/2024)

231c - Preadmission Screening

22. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/23. However, the resident's written cognitive preadmission screening was not completed.

231c - Preadmission Screening (continued)

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1. The written cognitive preadmission screening was completed on 12/4/23 by [redacted], RN.

2. Beginning December 2023 the Administrator will audit all preadmission screenings upon admission to verify all portions of the preadmission screening are completed to include that the Cognitive Screening portion is completed in collaboration with a physician or a geriatric assessment team.

3. Beginning December 27, 2023 the Administrator will document on the Monthly Preadmission Screening Summary upon admission to the SDCU that the resident preadmission screening is completed properly to include the Cognitive Screening section.

Licensee's Proposed Overall Completion Date: *01/23/2024*

Implemented [redacted] - 05/17/2024)

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

Facility Information

Name: *NORTHVIEW ESTATES* **License #**: *40499* **License Expiration**: *12/24/2024*

Address: *945 BORDER AVENUE, ELLWOOD CITY, PA 16117*

County: *LAWRENCE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *NORTHVIEW ESTATES LIMITED PARTNERSHIP*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/10/2001* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *65* **Waking Staff**: *49*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *03/27/2024*

Inspection Dates and Department Representative

03/27/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *First Floor* **Capacity**: *10* **Residents Served**: *8*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *55*

Diagnosed with Mental Illness: *20* **Diagnosed with Intellectual Disability**: *3*

Have Mobility Need: *10* **Have Physical Disability**: *0*

Inspections / Reviews

03/27/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/20/2024*

05/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/16/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/06/2024*

05/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/16/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/15/2024*

05/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/16/2024*

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

17 - Record Confidentiality

1. Requirements

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

Description of Violation

At 10:00am, bowel movement logs, appetite logs and staff notes for resident #1, resident #2, and resident #3 were unlocked, unattended, and accessible on top of the refrigerator/freezer in the secure dementia care unit.

Plan of Correction ***Accept [redacted] - 05/08/2024)***

1. The bowel movement log and appetite log were removed from the top of the refrigerator on 3/27/24 by the Care Manager of the dementia care unit and placed in a locked location.
2. Disciplinary action was taken against the Care Manager of the dementia unit on 4/18/24 for failing to follow the facility policy on Resident Charts.
3. The facility policy on resident charts was updated by the Administrator on 4/18/24 and will be reviewed with all direct care staff by the Administrator by 4/25/24.
4. Beginning 4/18/24 the Care Manager of the Dementia Unit will check all common areas in the Dementia Unit at the beginning of his/her shift to ensure all resident records are maintained in a secured location. Documentation of the Care Manager checking the common areas in the Dementia Unit will be maintained on the Quality Management Checklist SDU.
5. Beginning 4/18/24 the Administrator will check the Secured Dementia unit weekly to ensure all resident records are maintained in a secured location. Documentation of these checks will be maintained on the Quality Management Checklist SDU by the Administrator.

Licensee's Proposed Overall Completion Date: *05/06/2024*

Not Implemented [redacted] 05/17/2024)

81b - Resident Personal Equipment

2. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

At 9:45am, the U-shaped enabler bar attached to resident #4's bed was not securely attached and was able to move more than 10 inches in all directions, posing an entrapment hazard.

At 10:00am, the U-shaped enabler bar attached to resident #1's bed was not securely attached and was able to more than 10 inches in all directions, posing an entrapment hazard.

Repeat Violation: 9/12/2022 et al

Plan of Correction ***Accept [redacted] - 05/01/2024)***

1. Resident #4 and resident #1's enabler were securely attached to their beds by the maintenance man on 3/27/24.
2. The facility's Admission Agreement was updated by the Administrator on 4/18/24 to include a section under

81b - Resident Personal Equipment (continued)

house rules explaining the facility protocols on assistive devices.
3. The facility protocols on assistive devices will be mailed to all residents and or their responsible parties by the administrator and office manager on or before 4/22/24.
4. The facility policy on Bed Rails, Restraints, Enabler Bars, Handles was reviewed by the administrator with the maintenance man on 4/18/24.
5. Beginning 4/18/24 the maintenance man at the facility will check all enabler bars weekly to ensure the enabler bars are securely attached to the bed and is free of hazards. Beginning 4/18/24 documentation that the maintenance man checked all enabler bars will be kept by the maintenance man on Assistive Devices Safety Checklist.
6. The administrator checked all enabler bars on 4/18/24 to ensure the enabler bars utilized by any resident is properly secured and free of hazards.
7. Beginning 4/19/24 the Administrator will review the Assistive Devices Safety Checklist weekly to ensure all enabler bars are being checked.

Licensee's Proposed Overall Completion Date: *04/18/2024*

Not Implemented [redacted] - 05/17/2024)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

The home has a house glucometer that was used to measure the blood glucose levels of unidentified residents in the home multiple times in December 2023. The same house glucometer was used to measure resident #5's blood glucose levels on the following dates and times:
3/17/24 at 11:01am - 353
3/17/24 at 3:48pm - 117
3/18/24 at 7:06am - 207
3/18/24 at 10:57am - 267
3/18/24 at 3:33pm - 249
3/19/24 at 7:19am - 199
3/19/24 at 10:53am - 473
3/19/24 at 3:26pm - 150
3/20/24 at 6:59am - 176
3/20/24 at 10:53am - 382
3/20/24 at 3:38pm - 252
3/21/24 at 10:50am - 436

Plan of Correction ***Accept [redacted] 05/08/2024)***

1. The house glucometer was removed from the nurses station on 3/27/24 by the administrator.
2. The facility purchased a glucometer on 4/7/24 as an emergency glucometer in the event a resident's glucometer is not functioning or test strips are not available.
3. The facility policy on Accu Checks was updated by the Administrator on 4/4/24 to include protocols on the

85a - Sanitary Conditions (continued)

emergency glucometer to include that the new emergency glucometer will only be used for that resident and that the Administrator is to be notified so as to purchase a new emergency glucometer.

4. The facility policy on Accu Checks was reviewed by the Administrator with all staff responsible for administering medication on 4/4/24.

5. Resident #5's physician was notified on 5/6/24 that the resident shared a glucometer from 3/17/24 to 3/21/24.

6. Beginning 5/6/24 the Administrator or Resident Care Coordinator will observe weekly for 4 weeks and then monthly for 2 months each staff person responsible for diabetic care perform blood glucose checks to ensure each resident glucometer is used only for the resident to whom it belongs. Documentation of the observations will be kept on the Blood Sugar Insulin Administration Log.

Licensee's Proposed Overall Completion Date: *05/06/2024*

Not Implemented ([redacted] - 05/17/2024)

85d - Trash Receptacles

4. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 8:40am, there was no trash can in the bathroom of resident bedroom #207A.

Plan of Correction ***Accept ([redacted] - 05/08/2024)***

1. A garbage can was placed in room 207's bathroom on 3/27/24 by the Office Manager.

2. The facility's Resident Living Area Quality Management Checklist was updated by the Administrator on 4/19/24.

3. Beginning 4/21/24 the Housekeeper and Care Manager of the Dementia Unit will check all resident rooms weekly to ensure there is a trash receptacle present in each resident's bathroom. Documentation of checks will be maintained on the Resident Living Area Quality Management Checklist.

4. Beginning 4/21/24 the Administrator will verify weekly that the Resident Living Area Quality Management Checklist is completed. Documentation will be maintained by the Administrator on the Facility Quality Management Checklist.

Licensee's Proposed Overall Completion Date: *05/06/2024*

Not Implemented [redacted] - 05/17/2024)

184a - Resident's Meds Labeled

5. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.

184a - Resident's Meds Labeled *(continued)*

5. The name and title of the prescriber.

Description of Violation

Resident #6 is prescribed Meclizine (Antivert) 25mg tablet, take 1 tablet by mouth every 6 hours as needed; however, the medication's pharmacy label indicates to take 1 tablet 3 times (every 8 hours) per day.

Plan of Correction ***Accept [redacted] - 05/01/2024)***

1. An order change label was placed on resident #6's Meclizine on 3/27/24 by the nurse.
2. All staff administering medications were trained on 4/4/24 by the Administrator on the facility's policy on medication orders.
3. Beginning 4/5/24 all new orders for resident will be logged on the Physician Order Record. The Resident Care Coordinator will double check all new orders during her shift and verify all orders are properly labeled according to the regulation and the facility policies on resident orders.
4. All resident orders will be checked by the Resident Care Coordinator by 4/27/24 to ensure all medications match the MAR and the orders. Documentation will be kept on the Medication Reconciliation Form.
5. Beginning April 2024 the Resident Care Coordinator will check all resident medications monthly to ensure medications are properly labeled to match the MAR. Documentation of these checks will be maintained on the Medication Reconciliation Form.
6. Beginning 4/21/24 the Administrator will verify the completion of the Medication Reconciliation Form weekly and document on the Facility Quality Management Checklist.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented [redacted] - 05/17/2024)

184b - Labeling OTC/CAM

6. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #5 is prescribed Aspirin 81mg, take 1 tablet by mouth daily. However, the over-the-counter medication container was not labeled with the resident's name.

Plan of Correction ***Accept ([redacted] - 05/01/2024)***

1. Resident 5's name was placed on the Aspirin by the nurse on 3/27/24.
2. All staff administering medications were trained on 4/4/24 by the Administrator on the facility policy on medication ordering, receipt and disposal.
3. Beginning 4/5/24 all new orders for resident will be logged on the Physician Order Record. The Resident Care Coordinator will double check all new orders during her shift and verify all orders are properly labeled according to the regulation and the facility policies on resident orders to include the resident's name being on all medication.
4. All resident medications will be checked by the Resident Care Coordinator by 4/27/24 to ensure all medications contain the resident's name. Documentation will be kept on the Medication Reconciliation Form.
5. Beginning April 2024 the Resident Care Coordinator will check all resident medications monthly to ensure medications are properly labeled to match the MAR. Documentation of these checks will be maintained on the Medication Reconciliation Form.
6. Beginning 4/21/24 the Administrator will verify the completion of the Medication Reconciliation Form weekly and document on the Facility Quality Management Checklist.

Licensee's Proposed Overall Completion Date: *04/19/2024*

184b - Labeling OTC/CAM *(continued)*

Implemented [redacted] - 05/17/2024)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #5 is prescribed Insulin Apart 100 units/ml pen, inject subcutaneously 3 times per day, 8 units if blood sugar is greater than 200.
On 3/10/24 at 6:45am, resident #5's blood glucose reading was 120; however, the resident was administered 8 units.
On 3/23/24 at 5:00pm, resident #5's blood glucose reading was 163; however, the resident was administered 8 units.

Resident #7 is prescribed Novolog Insulin 100 units/ml pen, inject subcutaneously before meals per sliding scale: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, >400 = call MD.
On 3/25/24 at 4:30pm, resident #5's blood glucose reading was 241. According to the prescriber's orders, the resident should have been administered 4 units; however, the resident was administered 6 units.

Plan of Correction ***Accept[redacted] - 05/01/2024)***

1. Disciplinary action will be taken by the Administrator against the staff persons responsible for administering the medication on or before 4/26/24.
2. All staff administering medications were trained on 4/4/24 by the Administrator on the facility policy on Accu Checks and Insulin Administration.
3. The facility's Blood Sugar and Insulin Administration Quality Assurance Log was updated by the Administrator on 4/18/24 to include the verification that the unit of insulin administered was correct.
4. Beginning 4/21/24 the Resident Care Coordinator will check all resident insulin units administered weekly. Documentation of checks will be maintained on the Blood Sugar and Insulin Administration Log.
5. Beginning 4/22/24 the Administrator will verify the completion of the Blood Sugar and Insulin Administration Log weekly. Documentation will be maintained on the facility Quality Management Checklist.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Not Implemented [redacted] - 05/17/2024)