pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SYCAMORE ESTATES, LLC**
LEGAL ENTITY

To operate **SYCAMORE ESTATE PERSONAL CARE RESIDENCE**
NAME OF FACILITY OR AGENCY

Located at **717 DUQUESNE BLVD, DUQUESNE, PA 15110**
(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 **49**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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 **June 21, 2024** until **December 21, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454502**

ISSUING OFFICER

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: JUNE 21, 2024

[redacted]
Sycamore Estates, LLC
717 Duquesne Blvd.
Duquesne, Pennsylvania 15110

RE: Sycamore Estate Personal Care Residence
License/COC #: 454502

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, Office of Long-Term Living licensing inspections on March 11, 2024, and May 6, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LISs) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from June 21, 2024 to December 21, 2024.

All violations specified on the LISs 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)
183(e)	II	30	$5	$150	5 calendar days from mailing date of this letter
184(a)	II	30	$5	$150	5 calendar days from mailing date of this letter
187(a)	II	30	$5	$150	5 calendar days from mailing date of this letter
187(b)	II	30	$5	$150	5 calendar days from mailing date of this letter
187(d)	II	30	$5	$150	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 each violation is fully corrected, and full compliance with the regulation has been achieved. If each 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 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 PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Lestia Fetzer, Workload Manager
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: *SYCAMORE ESTATE PERSONAL CARE RESIDENCE* **License #:** *45450* **License Expiration:** *06/08/2024*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA 15110*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *SYCAMORE ESTATES, LLC*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA, 15110*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/14/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *37* **Waking Staff:** *28*

Inspection Information

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

Reason: *Complaint, Provisional* **Exit Conference Date:** *03/11/2024*

Inspection Dates and Department Representative

03/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served:** *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *31*

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

Have Mobility Need: *4* **Have Physical Disability:** *0*

Inspections / Reviews

03/11/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/23/2024*

Inspections / Reviews *(continued)*

03/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/25/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/01/2024*

04/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/25/2024*

Reviewer [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/17/2024*

05/31/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/25/2024*

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

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

From approximately 9:05 a.m. until 9:35 a.m. the administrator's office was left unlocked, unattended, and accessible with all of the home's resident records within in addition to multiple other items of protected health information to include:

- *Empty medication bottles for resident #1 and resident #2 on direct care staff person A's desk.*
- *A medication administration record for resident #3 on staff person B's desk.*
- *Physicians orders and prescription orders for resident #4 on direct care staff person A's desks*

REPEAT VIOLATION 6/22/23 et. al.

Plan of Correction ***Directed [redacted]- 04/03/2024)***

Home response:

The workspace for both Staff Persons A and B is located in a room marked "Private" secured with an electronic lock that automatically locks when the door shuts. Only authorized staff with the key code may access room. During a brief part of the inspection, Staff Person A was going back and forth between this secure space to the office space provided to the inspectors in order to bring them requested records. The door must have been left cracked open, allowing Inspector [redacted] to circle back and sneak into this room without permission.

POC:

Staff Person B had no information on their desk for Resident #3 and this violation is disputed. We request documentation showing that Resident #3's medication administration record was on the desk. The home also disputes the propriety of the inspector entering a private area while unaccompanied.

Resident records shall continue to be kept confidential within the locked private office space. Any Resident records that are in use in this space are not accessible to unauthorized individuals. Residents' empty medication bottles, physician orders, and prescription orders will be either disposed or stored in the resident's respective binder. The office will continue to remain locked at all times, including during inspections. If for some reason the inspectors need access to this room, they will be accompanied by a Staff Person A or B.

POC revision as requested 3-25-24

The violation was corrected for Residents 1, 2 and 4, by re-ordering the medications, or filling the prescriptions and disposed or charted to resident file. This was completed by Staff person A, and was corrected on 3/12/24.

Staff member A has the training and will oversee maintaining compliance with the regulation, being the home administrator. [redacted] will assure that confidential information is maintained in a manner that prevents unauthorized access. Staff member B will add a self closing door closure to the office access door to ensure the door is not

17 - Record Confidentiality (continued)

accidently left open.

Our monitoring step will include a week review of our open office space areas, to ensure no resident documents were inadvertently not placed in resident folders, or binders. This monitoring will begin at the acceptance of this POC by the department. The monitoring will be done by The Administrator.

A log of our weekly checks will be maintained.

Proposed Overall Completion Date: 04/08/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.17 and the home's policies and procedures for maintaining compliance with Regulation 2600.17. Documentation shall be kept in accordance with Regulation 2600.65(i). 3/4/24[redacted]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24[redacted]

Directed Completion Date: *04/08/2024*

Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***- 05/31/2024)***

44g - Telephone Number

4. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP), the Commonwealth Information Center and the personal care home complaint hotline were not posted in a conspicuous and public place in the home. The posted number for the personal care home complaint hotline was incorrect and indicated "1-800-254-5464."

Plan of Correction ***Accept*** [redacted] ***- 04/03/2024)***

POC:
The poster of required phone numbers provided by Inspector [redacted] *e was posted after the correct numbers for the area agencies were added. This poster was placed at the information board in the great room as well as beside the phone area for residents use and access.*

The continued placement of this poster will be checked by the administrator quarterly and will confirm correct phone numbers as well as the local website for ombudsman contacts.

As stated in the POC...The continued placement of this poster will be checked by the administrator quarterly and will confirm correct phone numbers as well as the local website for ombudsman contacts. This Was completed in the April Quarterly check as well as July quarterly check etc.

44g - Telephone Number (continued)

POC revision as requested 3-25-24

The corrective action was completed on 3-12-24. The form that was used was emailed by [redacted] to Staff Member A, filled out with the required information and posted at the community bulletin board.

Monitoring will start on the date of acceptance of this POC. The monitoring will include the information as well as the other required information required by 44g. The Administrator with be monitoring bi- monthly.

A log of our bi-monthly checks for be maintained.

Licensee's Proposed Overall Completion Date: *04/08/2024*

Licensee's Proposed Date for POC Implementation ***Implemented ([redacted] 05/31/2024)***

64c - Annual Training

6. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Direct care staff person A, the home's [redacted] completed only 12 hours of Department-approved training in training year 1/1/23 to 12/31/23.

Plan of Correction ***Accept [redacted] 04/03/2024)***

POC:

Staff Person A will complete the required 24 hours of annual training going forward. If Staff Person A is required to complete additional training to make up for any past hours not completed, please advise and [redacted] will be enrolled in the necessary training to be completed within the next 90 days.
The Administrator included the certifications of the courses completed in 2023 The Administrator will be responsible for self auditing of continuing education.

POC revision as requested 3-25-24

Attached is Staff A documents for [redacted] 24 hour training requirements. It appears [redacted] has the 24 hours as of 12-31-23. The inspectors reviewed this information and took exception but did not provide any specifics. Also, the write up provides not specifics as to the short fall of hours for 2023.

It is our understanding the department is only allowing 6 hours of credit for the train the trainer course instead of the 12 hours stated as course credits. While this was unknown we have add another attachment showing the log for the 2023 hours, the credit adjustment from 24 to 18 hours, and added the 6 credit hours for the "Safe Management" course completed on 3-28-24. This covers the required hours for 2023 and are being submitting this hours to cover the alleged shortfall of hours in 2023. In addition, these hours will no longer by part of the 2024 hour count.

64c - Annual Training (continued)

Our monitoring will be self monitoring by Staff Member A. All documents will be kept in Staff A continuing education binder for the department's review. In addition, Staff member A with provide and electronic copy of all scheduled, and completed continuing education hours to Staff member B for a redundancy.

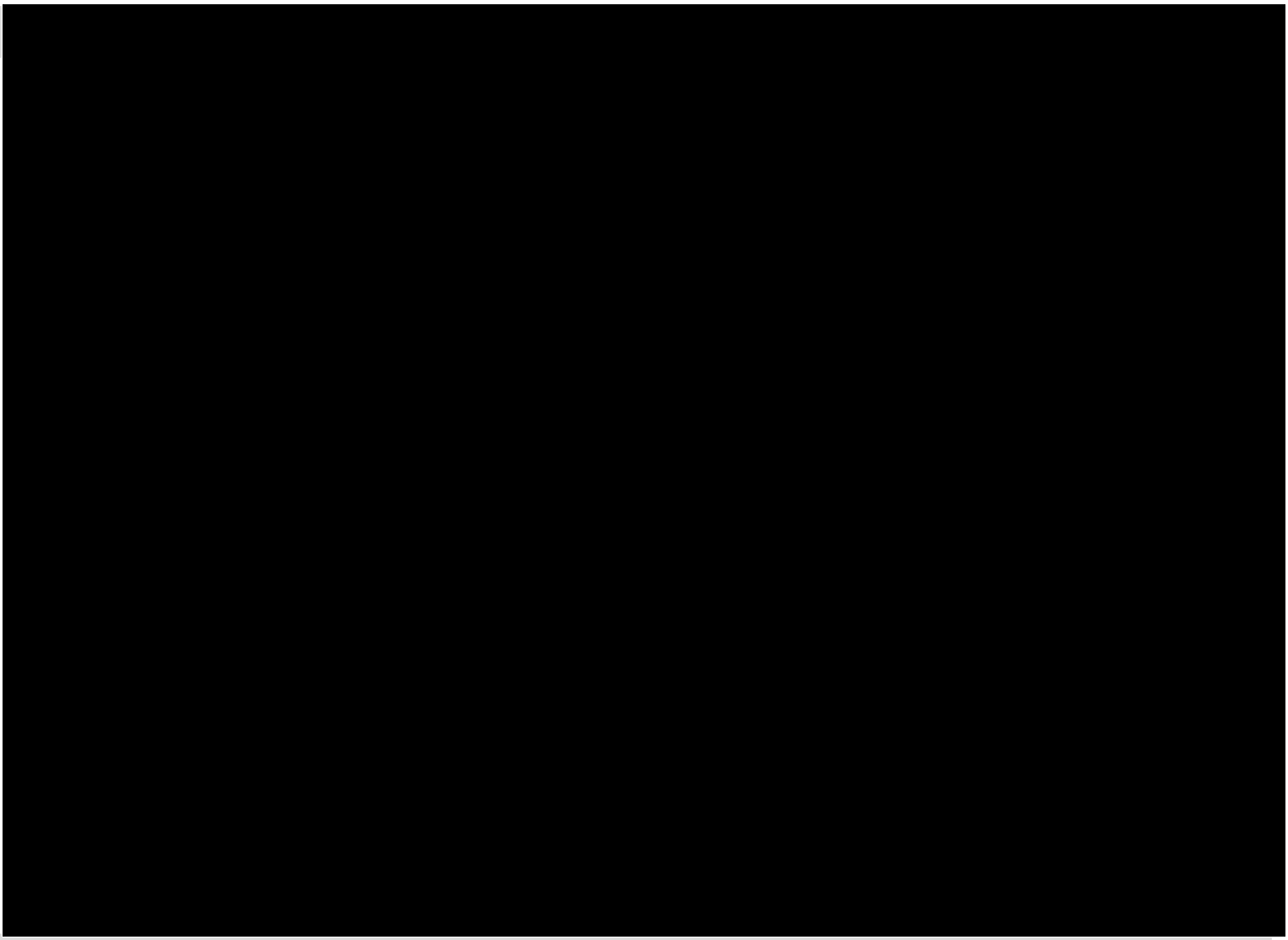
A credit log of hours will be kept just like the one attached to the file dated 3/29/24.

Licensee's Proposed Overall Completion Date: *04/11/2024*

Licensee's Proposed Date for POC Implementation

Implemented [redacted]05/31/2024)

[redacted]



85e - Trash Outside Home

8. 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

At approximately 8:55 a.m. the left lid of the dumpster in the parking lot was open and it was approximately one-half full of trash bags and other loose garbage.

Plan of Correction ***Directed [redacted] 04/03/2024)***

Home response:

The dumpster lids were thrown open by heavy winds, in an "Act of God" event. While we did verify this happened and closed the lid as soon as it was discovered, we dispute this is a violation that should be included in this report. On Sunday evening, March 10th and early Monday morning, March 11th, we had high winds, and snow flurries. Our dumpster meets all safety and health codes of the department and the lids are always kept closed. We would have discovered this on our own, but [redacted] parked right next to the dumpster and noticed the lid was open first. It was closed within minutes. Our staff knows to keep all sliding doors and lids closed on this dumpster. In fact, it is difficult for staff to open the lid to the point it does not close on its own due to the height and weight of the lid.

85e - Trash Outside Home (continued)

POC:
All staff will continue to keep the lids and doors of the dumpster closed. Given that we are not responsible for "Acts of God" we ask the department to retract this violation. Please advise if this request is acceptable by April 1, 2024.

POC revision as requested 3-25-24

Since 3-25-24 we ordered signage to say " Notice - Keep this door closed" and "Keep dumpster lid shut". Our dumpster had both small sliding doors on the sides, and twin lids. One sign for each door and lid was purchased and will be installed upon arrival. See attach order.

Staff person A will include this item on the continuing education for all staff members.

Our monitoring step will be daily upon arrival to the parking lot. Monitoring will include closed lids and doors on dumpster as well as to confirm no trash is outside the dumpster. Monitors with one of the following Staff persons being A and B, D. and E.

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24[redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation

Implemented [redacted] ***05/31/2024)***

86b - Bathroom

9. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

At approximately 10:12 a.m., the ventilation fan in the bathroom of resident room #E-2 belonging to resident #2 was inoperable and there was no window.

Plan of Correction ***Directed*** [redacted] ***04/03/2024)***

Home response:
This room was checked by Staff person B the week of March 4th at which time the exhaust fan was working.
POC:
The fan will be checked to confirm it is not working and will be replaced or repaired as required. The balance of the bathroom fans will be checked for proper operation and repaired/replaced if not in working order.

POC revision as requested 3-25-24

The fan will be replaced or repaired the week of April 8, 2024 and the correction will be uploaded to Sanwrite. Staff

86b - Bathroom (continued)

member B will manage the corrective action required, and the corrective work will be completed by April 11th.

One of our two housekeeping staff will be trained on checking all exhaust fans during the cleaning of all bathroom and shower rooms. The item will be added to our room check log currently in use. A copy of this log will be uploaded to Sanswrite by April 11th to confirm this violation was corrected.

Weekly room checks will be done and logged.

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24 [redacted]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall ensure the education indicated in the home's plan of correction is implemented. 4/3/24 [redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***- 05/31/2024)***

96a - First Aid Kit

10. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The home's first aid kit did not include adhesive tape or adhesive bandages.

Plan of Correction ***Directed*** [redacted] ***- 04/03/2024)***

POC:

The first aid kit is behind our unlocked care staff work area and was restocked with adhesive tape and bandages on the March 11, 2024 after being notified of the missing items. Therefore, this violation was immediately remedied.

Our training on April 4, 2024 will include instruction on appropriately re-stocking the kit by staff in a timely manner.

POC revision as requested 3-25-24

In addition to our previously submitted POC we will do a bi-weekly monitoring and keep a log including the items that were re-stock if any, with date. Items being monitored will be includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Our Staff manager with be the one to do the bi-weekly check and log.

96a - First Aid Kit (continued)

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24 .

Directed Completion Date: *04/11/2024*

Licensee's Proposed Date for POC Implementation ***Implemented - 05/31/2024)***

101j7 - Lighting/Operable Lamp

11. Requirements

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

Description of Violation

At approximately 10:29 a.m. the lamp on the bedside table in resident room #E-7 belonging to resident #5 was inoperable, the lamp was unplugged and all receptacles in the closest outlet were occupied by other plugs.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Directed 04/03/2024)***

Home response:

Both residents in E-7 are on Hospice services. The lamp in question was unplugged by the aid from Hope Hospice to charge the Hoyer lift battery backup, the battery charger was relocated to the staff station where it will be accessible to hospice aides and staff. The lamp was plugged back in on 03/11/2024.

Staff members from the outside agencies were notified about this regulation, by the administrator. All hospice aids will be notified going forward. Neither of these residents are capable of turning on a light and this should be treated as an exception and not a repeat violation due to these special circumstances.

We therefore request this violation be retracted. Please confirm by April 1, 2024.

POC revision as requested 3-25-24

The light was plugged back in and tested on 3/11/24 by our staff manger.

Our housekeeping staff who monitor the resident lamps have already by re-trained to include a check for any modifications made by outside agencies such as hospice service companies. Re-training was done by Staff member A.

Housekeeping staff will do their checks per their room cleaning schedule, Our staff manager or Staff member A will do a weekly room check which will include lights.

101j7 - Lighting/Operable Lamp (continued)

A log of the weekly checks will be kept on site.

Letter to Hope Hospice attached.

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24 [redacted]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall ensure the education indicated in the home's plan of correction is implemented. 4/3/24 [redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 5/31/24)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

12. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There was no grab bar in the shared resident bathroom of resident room #10 North belonging to resident #6 and resident #7.

REPEAT VIOLATION 6/22/23 et. al.

Plan of Correction ***Directed [redacted] - 04/03/2024)***

Home response:

This is not a repeat violation. On 6/22/23 the inspector insisted on grab bar for a staff bathroom. This bathroom was 15 years old and no one from the department ever questioned it. We installed the grab bar without contesting it but we will not accept this one being a repeat violation and respectfully request is being modified to only a violation. Please confirm this request by April 1, 2024.

POC:

The original grab bar will be re-installed. All other resident bathrooms will be checked to confirm compliance. It was assumed all bathrooms were checked by the Department on 6/22/23. This will be completed by April 12, 2024.

POC revision as requested 3-25-24

Staff member B has been self trained on this regulation and will be reasonable for maintaining compliance. Education was completed on March 20th. The missing grab bars will be re-installed by April 11th.

Since the monitoring is a fixed item it will be quarterly and done by Staff member B. Also, the weekly housekeeping checks will include a line item for grab bars.

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface (continued)

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24 [redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***05/31/2024)***

125a - Combustible Storage

13. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At approximately 11:05 a.m. the home had multiple combustible materials touching the natural gas operated furnaces in the basement to include a cardboard box for a furnace control replacement module that was stored to the left of the [redacted] *furnace and what appeared to be a paper instruction manual that was folded and stored on the right side of the Goodman furnace.*

Plan of Correction ***Directed*** [redacted] ***04/03/2024)***

POC:
The manuals and one small part box were removed during the inspection by [redacted] *Attached is a photo of the items that were removed showing their new placement.*

No combustible materials will be stored within 36" of any units.

POC revision as requested 3-25-24

Staff member A and B met and discussed this violation and understand the regulation. Staff member B with be the responsible for maintaining compliance, We completed the education on March 18th when we reviewed NFPA which states:

Keep anything that can burn at least three feet (one meter) away from all heating equipment, including furnaces, fireplaces, wood stoves, and space heaters. Always use the right kind of fuel, as specified by the manufacturer, for fuel-burning space heaters.

A photograph of the items that were removed in front of the inspector and placed in another area of the basement is attached.

Staff member B will do a monthly inspection of all areas where hot water heaters and furnaces are present and log the review.

125a - Combustible Storage (continued)

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24[redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation

Implemented [redacted] ***05/31/2024)***

132c - Fire Drill Records

14. 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

On 9/29/23 at 1:15 p.m. the home conducted a fire drill in four minutes and eleven seconds with 31 residents in the home. However, the fire drill record did not indicate the exit route used to evacuate the residents to a public thoroughfare and indicated "All East Blocked".

On 10/16/23 at 11:15 a.m. the home conducted a fire drill in four minutes and four seconds with 31 residents in the home. However, the fire drill record did not indicate the exit route used to evacuate the residents to a public thoroughfare and indicated "North Blocked".

On 11/21/23 at 5:30 a.m. the home conducted a sleeping hours fire drill in four minutes and twenty-three seconds with 26 residents in the home. However, the fire drill record did not indicate the exit route used to evacuate the residents to a public thoroughfare and indicated "East Ex Block".

On 12/17/23 at 8:05 a.m. the home conducted a fire drill in four minutes and forty-five seconds with 26 residents in the home. However, the fire drill record did not indicate the exit route used to evacuate the residents to a public thoroughfare and indicated what appeared to be "North Fire Tower".

On 1/12/24 at 6:15 p.m. the home conducted a fire drill in four minutes and thirty-six seconds with 30 residents in the home. However, the fire drill record did not indicate the exit route used to evacuate the residents to a public thoroughfare and indicated "Door 1 Blocke".

On 2/14/24 at 1:15 p.m. the home conducted a fire drill in four minutes and twenty-three seconds with 31 residents in the home. However, the fire drill record did not indicate the exit route used to evacuate the residents to a public thoroughfare and indicated "East FT Blocked".

Plan of Correction ***Directed*** [redacted] ***- 04/03/2024)***

POC:

132c - Fire Drill Records (continued)

An updated letter is attached from the local fire chief that confirms the safe areas of the home and that a 5 minute time to evacuate the residents and staff will suffice. An older letter was on file but the inspectors did not want to accept it. The attached current letter supports the past letters that were on file, restating the original 5 minute time for evacuation as well as listing the fire safe areas that may be used. This has been done, in addition to our annual fire safety inspection with our fire chief [redacted] Scheduled for April 1, 2024.

All future monthly fire drill records will state exit used and exit blocked when we block one for any monthly drill. The administrator or her designee will be conducting all future fire drills and document the same. Please see attached the fire drill for March

POC revision as requested 3-25-24

In all six fire drills records, the inspectors violation was specific for not detailing the "exit route used". While we cannot correct the past logs we have attached a supplement log to show we added a column for exit location. We will specific the exit route or routes used going forward. This was implemented by Staff Member A on March 20th.

We will have the local fire chief on site for annual fire safety inspection on April 1st and Staff member A and our staff manager with be attending and be re-trained in the requirements for performing and documenting a fire drill.

Staff member B will be reviewing the fire drill reports monthly.

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24 [redacted]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate the staff persons who complete the fire drill record on the requirements of Regulation 2600.132(c). Documentation of education shall be kept in accordance with Regulation 2600.65(i). 4/3/24 [redacted]

Directed Completion Date: *04/11/2024*

Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***- 05/31/2024)***

141a 1-10 Medical Evaluation Information

15. 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 #5's medical evaluation, dated [redacted]/23, did not include the resident's weight, pulse rate, blood pressure or temperature, those areas of the evaluation were left blank.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

Home response:
This was an oversight by the medical professional or [redacted] staff conducting these evaluations

POC:
Resident 5 will have a follow up with [redacted] to update her DME on Wednesday April 3, 2024 at 1pm.
The administrator checked all resident DME and RASPs for correct information. This was completed on 03/15/2024.
A sampling of 5 residents will be done monthly for both new and annual recertification's for existing residents by the administrator and kept in their charts for review.

We will also have a discussion with Dr. Chen about this regulation and advise him of the violation.

Licensee's Proposed Overall Completion Date: *04/03/2024*
Licensee's Proposed Date for POC Implementation Not Implemented [redacted] - 5/31/24)

183e - Storing Medications

16. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

At approximately 2:18 p.m. there was a bottle of Atropine SL Solution 1% that belonged to resident #5 that was labeled as expired 9/16/23 and was found in the drawer of the refrigerator of the medication room.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Directed [redacted] 04/03/2024)***

Home response:

This Atropine was an eKit item that was not opened and was discontinued.

183e - Storing Medications (continued)

POC: This eKit will not be ordered until needed due to the extremely short shelf life. As a hospice patient, the pharmacy will provide a 24 hour delivery and it can be easily obtained. The medication was destroyed by the hospice nurse the day of the inspection 03/11/2024.
The discontinuation orders provided by Hospice were given to the lead inspector [redacted] on 03/11/2024.

We will provide notice to all of our hospice firms that we will no longer accept and store eKits.
The medication techs and the two techs in training were trained on 3/27 at 1:00 pm by Administrator [redacted] who is a trainer
The Medication techs and the designee will do checks of different section of the med room for cleanliness, expirations and current supply of medications based on a weekly schedule. See attached agenda, sign in list and check list.

POC revision as requested 3-25-24

We have 7 current staff members certified as med techs. as required under 190a, and on March 27th they all reviewed this violation in detail with Staff member A and discussed the requirements, Their names are attached to the sign in sheet for the education training. Our agenda for the meeting is also attached. All med techs are self monitoring staff for regulatory for 183e, 184a, 185a, 187a, 187b, and 187d.

These 7 staff members will not only self monitor themselves but will monitor each other as well on a daily basis. The monitoring step by management will be staff member A, and the staff manager. Weekly monitoring for this regulation will be done by one of these two staff members, and logged on the day and time of their review.

Staff member B will be provide the weekly reports for confirmation of continued weekly monitoring.

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24[redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 5/31/24)

184a - Resident's Meds Labeled

17. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #2's Metoprolol Succinate indicated, "100mg tablets, take one-half tablet by mouth daily." However, resident #2 is prescribed Metoprolol Succinate 50mg tablet, take one-half tablet by mouth daily, hold if systolic blood pressure is less than 110 and heart rate less than 55.

The pharmacy label for resident # 5's Morphine 20mg/1ml 10mg (0.5mL)0.25ml syringe indicated "Morphine

184a - Resident's Meds Labeled (continued)

100mg/5ml 1 syringe 0.25ml/5mg, 1 syringe 0.25ml/5mg every hour as needed." However, resident #5 is prescribed Morphine 20mg/1ml 10mg (0.5mL)0.25ml syringe, give 0.5ml every two hours as needed.

The pharmacy label for resident #8's Tamsulosin 0.4mg capsule indicated, "Take 2 capsules by mouth daily approximately one hour after dinner." However, resident #8 is prescribed Tamsulosin 0.4mg, take one capsule by mouth once daily in the morning.

REPEAT VIOLATION 9/19/23

Plan of Correction ***Directed [redacted] - 04/03/2024)***

Home response:

We have our own pharmacy, Health Direct, who provides the majority of our medications in either strip or card format. Unfortunately, these three specific residents have other sources for their providers. Resident 2 has a VA pharmacy, Resident 5 has a hospice pharmacy, and resident 8 has CVS pharmacy. Since it is discovered that all of these outside pharmacies made mistakes, and the burden is being passed through to our home, and our med techs, we are considering not allowing these outside pharmacies to service our home. In the meantime, we know about this issue and submit our POC below.

We will also look into how to file complaints against the pharmacies for their errors in these specific events.

POC:

At Inspector [redacted] suggestion we will provide a generic label for all outside providers, that simply states "see MAR for additional information". This will alert all Med Staff that this is not our pharmacy and to be extra observant in dispensing.

All MED TECH staff will be retrained to follow the MAR and double check this step and report to the administrator any discrepancies they find. After training, a copy of the training and the sign in sheet will be kept it the office for review. Training is scheduled for 03/27/2024.
The medication techs and the two techs in training were trained on 3/27 at 1:00 pm by Administrator [redacted] who is a trainer
The Medication techs and the designee will do checks of different section of the med room for cleanliness, expirations and current supply of medications based on a weekly schedule. Started 03/27/2024 See attached agenda, sign in list and check list. and medication audit

POC revision as requested 3-25-24

We will continue to monitor outside pharmacies for compliance with our home policies. We we will not do any labeling to say within the requirements of 2600.184a.

We have 7 current staff members certified as med techs. as required under 190a, and on March 27th they all reviewed this violation in detail with Staff member A and discussed the requirements, Their names are attached to the sign in sheet for the education training. Our agenda for the meeting is also attached. All med techs are self monitoring staff for regulatory for 183e, 184a, 185a, 187a, 187b, and 187d.

184a - Resident's Meds Labeled (continued)

These 7 staff members will not only self monitor themselves but will monitor each other as well on a daily basis. The monitoring step by management will be staff member A, and the staff manager. Weekly monitoring for this regulation will be done by one of these two staff members, and logged on the day and time of their review. 5 individual

Staff member B will be provide the weekly reports for confirmation of continued weekly monitoring.

Attachments include sign in sheet, agenda for training,

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the medication labels for residents #2, #5, and #8 have been corrected. 4/3/24[redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented[redacted] - 5/31/24)

185a - Implement Storage Procedures

18. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The home's procedure for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons indicated, "medications may not be prepared (poured) more than two hours in advance, and must be in a lidded container with the resident's name on it." However, at approximately 2:05 p.m. there was one-half of an unidentifiable tablet of medication with what appeared to be an "R" stamped on the tablet that was sitting loose inside of a wicker rope basket that contained medications for resident #8. The medication did not appear to belong to resident #8.

Plan of Correction ***Directed*** [redacted] ***- 04/03/2024)***

POC:

Apparently, resident 8 who is fairly new to our home, brought a wicker basket for their medicines which we accepted for our use.
All resident medicine trays will be replaced with clear plastic type trays which will prevent this type of event from occurring again.

In addition, we are going to assign our graveyard shaft med tech the nightly responsibility of reviewing and cleaning of the drawers. A check off sheet will be added to the daily med room cleaning schedule with a signature log.

185a - Implement Storage Procedures (continued)

Staff will be trained on the new updated cleaning schedule on 04/10/2024. Records of the training will be kept in the office for review.

Proposed training by 4/1/24

POC revision as requested 3-25-24

The medication techs and the two techs in training were trained on 3/27 at 1:00 pm by Administrator [redacted] *who is a trainer*
The Medication techs and the designee will do checks of different section of the med room for cleanliness, expirations and current supply of medications based on a weekly schedule. started 03/27/2024 See attached agenda, sign in list and check list.
Clear Plastic bins for each resident who have bottled medication were purchased and will be put into use as soon as they are delivered, see attached.

We have 7 current staff members certified as med techs. as required under 190a, and on March 27th they all reviewed this violation in detail with Staff member A and discussed the requirements, Their names are attached to the sign in sheet for the education training. Our agenda for the meeting is also attached. All med techs are self monitoring staff for regulatory for 183e, 184a, 185a, 187a, 187b, and 187d.

These 7 staff members will not only self monitor themselves but will monitor each other as well on a daily basis. The monitoring step by management will be staff member A, and the staff manager. Weekly monitoring for this regulation will be done by one of these two staff members, and logged on the day and time of their review.

The night staff started their review and cleaning on the March 27th.

Staff member B will be provide the weekly reports for confirmation of continued weekly monitoring.

Attachments include a purchase receipt to replace any odd type trays including wicker trays used for medication storage, as well as our updated job duties matrix to show the night shaft review and cleaning. Sign in sheet and agenda attached as well.

Proposed Overall Completion Date: 04/11/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the propre placement or disposal of the medication cited in the violation. 4/3/24 [redacted]

Directed Completion Date: *04/11/2024*
Licensee's Proposed Date for POC Implementation

Implemented [redacted] - 6/6/24)

187a - Medication Record

19. Requirements

2600.

187a - Medication Record *(continued)*

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #5's medication administration record for March 2024 did not include an area to document the administration of the medication Amlodipine Besylate 2.5mg tablet. However, resident #5 is prescribed Amlodipine Besylate 2.5mg tablet, take one tablet by mouth once daily.

Resident #5's medication administration record for March 2024 did not include an area to document the administration of an Acetaminophen 650mg suppository. However, resident #5 is prescribed Acetaminophen 650mg suppository, insert one rectally every four hours as needed for fever > 100.4 degrees.

Resident #5's medication administration record for March 2024 did not include an area to document the administration of the medication Atropine SL Solution 1%. However, resident #5 is prescribed Atropine SL Solution 1%, instill 2 drops under the tongue every hour as needed.

Resident #5's March 2024 medication administration record indicated, "ABHR 1 syringe, 1 syringe every 6 hours as needed." However, resident #5 is prescribed ABHR (1-12.5-2-20), apply 1 syringe topically to inner wrist or on neck behind ear every four hours as needed.

Resident #5's March 2024 medication administration record indicated "Lorazepam 2mg/ml 0.25ml syringe, give 0.25ml as needed." However, resident #5 is prescribed Lorazepam 2mg/ml 0.25ml syringe, give 0.25ml every hour as needed.

Resident #5's March 2024 medication administration record indicated "Morphine 100mg/5ml 1 syringe 0.25ml/5mg, 1 syringe 0.25ml/5mg as needed." However, resident #5 is prescribed Morphine 20mg/1ml 10mg (0.5mL)0.25ml syringe, give 0.5ml every two hours as needed.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Accept [redacted] 04/03/2024)***

Home response:
Here is another example that is very similar to those listed in 184a. The hospice pharmacy was not intergraded with our pharmacy, Health Direct, who uploads our MAR data for accuracy.

187a - Medication Record (continued)

POC:

Since we are no longer going to accept Ekit for storage, and monitoring, most of these items will be eliminated. Medications covered by hospice were obtained and sent to Health Direct for accurate transcription into the SMART program.

Atropine Drops and Tylenol suppositories were discontinued on 03/11/2024. These were all updated by Health Direct and Hope Hospice on 03/12/2024.

All MED TECH staff will be retrained to follow the MAR and double check this step and report to the administrator any discrepancies they find. After training, a copy of the training and the sign in sheet will be kept it the office for review. Training is scheduled 03/27/2024.

The Medication techs and the designee will do checks of different section of the med room for cleanliness, expirations and current supply of medications based on a weekly schedule to prevent future violations. started 03/27/2024

POC revision as requested 3-25-24

The Medication techs and the staff manager will do checks of different section of the med room for cleanliness, expirations and current supply of medications based on a weekly schedule to prevent future violations. started 03/27/2024.

We have 7 current staff members certified as med techs. as required under 190a, and on March 27th they all reviewed this violation in detail with Staff member A and discussed the requirements, Their names are attached to the sign in sheet for the education training. Our agenda for the meeting is also attached. All med techs are self monitoring staff for regulatory for 183e, 184a, 185a, 187a, 187b, and 187d.

These 7 staff members will not only self monitor themselves but will monitor each other as well on a daily basis. The monitoring step by management will be staff member A, and the staff manager. Weekly monitoring for this regulation will be done by one of these two staff members, and logged on the day and time of their review.

Staff member B will be provide the weekly reports for confirmation of continued weekly monitoring.

Licensee's Proposed Overall Completion Date: *04/01/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 5/31/24)

187b - Date/Time of Medication Admin.

20. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #5 is prescribed Amlodipine Besylate 2.5mg tablet, take one tablet by mouth once daily. However, on dates ranging from 3/1/24 through 3/11/24, resident #5 was administered the Amlodipine Besylate 2.5mg tablet and it was not documented at the time of administration on the March 2024 medication administration record.

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

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Directed [redacted] 04/03/2024)***

Home response:
This specific prescription was included on the February MAR as upload by Health Direct. We had no reason to believe that somehow Health Direct deleted it from the MAR for March. This is important to know that we vetted this one in February, 2024.

While the time may not have been documented it was documented. Due to an error by Health Direct, it was given as part of being in the strip package provided by Health Direct. Also, it is puzzling why 187b, is the exact same regulation that is already provided under 187a - item a13 and a14. We don't understand the redundancy and respectfully request this violation be moved to 187a, and this one be retracted.

POC:
Medications covered by hospice were obtained and sent to Health Direct for accurate transcription into the SMART program. This includes Amlodipine Besylate this was completed by Health Direct on 03/12/2024. Ekit medications are being deleted.

All MED TECH staff will be retrained to follow the MAR and double check the potential errors of the multiple pharmacies that service our home. The Med Techs will continue to report to the administrator any discrepancies they find. After training, a copy of the training and the sign in sheet will be kept it the office for review. Training is scheduled 03/27/2024.

The Medication techs and the designee will do checks of different section of the med room for cleanliness, expirations and current supply of medications based on a weekly schedule to prevent future violations, started on 03/27/2024 as well as MAR reviews done by the Administrator and her designee. on a monthly basis started March 15th 2024

POC revision as requested 3-25-24

We have 7 current staff members certified as med techs. as required under 190a, and on March 27th they all reviewed this violation in detail with Staff member A and discussed the requirements, Their names are attached to the sign in sheet for the education training. Our agenda for the meeting is also attached. All med techs are self monitoring staff for regulatory for 183e, 184a, 185a, 187a, 187b, and 187d.

These 7 staff members will not only self monitor themselves but will monitor each other as well on a daily basis. The monitoring step by management will be staff member A, and the staff manager. Weekly monitoring for this regulation will be done by one of these two staff members, and logged on the day and time of their review.

Staff member B will be provide the weekly reports for confirmation of continued weekly monitoring.

Proposed Overall Completion Date: 04/01/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator or designee shall complete a

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

weekly audit of all resident MARs for compliance with Regulation 2600.187(b). Documentation of audits shall be kept. 4/3/24 JK

Directed Completion Date: *04/04/2024*
Licensee's Proposed Date for POC Implementation Not Implemented [redacted] - 5/31/24)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident #2 is prescribed Metoprolol Succinate 50mg tablet, take one-half tablet by mouth daily, hold if systolic blood pressure is less than 110 and heart rate less than 55. However on dates ranging from 3/1/24 to 3/11/24, the home only had Metoprolol Succinate 100mg half tablets and resident #2 was administered a 50mg dose of Metoprolol Succinate.

Resident #2 is prescribed Novolog Flexpen Syringe, inject subcutaneously three times a day before meals per sliding scale as follows: 70-130=OU; 131-180=4U; 181-240=5U; 241-300=6U; 301-350=7U; 351-400=8U; > 400= 9units and call doctor. However, on 3/1/24 at 4:00 p.m. resident #2's blood glucose reading was 248 and resident #2 was administered 4 units of Novolog Insulin.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Directed [redacted] 04/03/2024)***

Home response:

Resident 2 medicines are VA provided. Metoprolol 50 mg versus 100 mg tablets was a pharmacy error. The pills come to us cut in half and we had no reason to question the dose was wrong.

Note: it is important to know that resident 2 has been very difficult to treat daily with [redacted] insulin management to the point we recently had [redacted] and [redacted] come and sit down with us to discuss the importance of [redacted] cooperation in doing his 3 checks before meals. [redacted] has been placed on a warning that if this continues, we will be forced to provide him 30 day notice to relocate.

POC:

Staff will be retrained on diabetic training and documentation for Insulin and blood sugars. We have scheduled this training on 04/17/2023 with diabetic educator [redacted] Copies of the training will be kept in the office for review.

All MED TECH staff will be retrained to follow the MAR and double check this step and report to the administrator any discrepancy's they find. After training, a copy of the training and the sign in sheet will be kept it the office for review. Training is scheduled 03/27/2024.

POC revision as requested 3-25-24

187d - Follow Prescriber's Orders (continued)

We have 7 current staff members certified as med techs. as required under 190a, and on March 27th they all reviewed this violation in detail with Staff member A and discussed the requirements, Their names are attached to the sign in sheet for the education training. Our agenda for the meeting is also attached. All med techs are self monitoring staff for regulatory for 183e, 184a, 185a, 187a, 187b, and 187d.

An incident report was prepared and shared with the involved people as detailed on the attached report dated 3/25/24. This report will be made part of the resident file by Staff member A.

The VA was notified of the prescription error for the Metoprolol Succinate 50mg tablet, and it has been replaced with the correct dosage.

The Medication techs and the designee will do checks of different section of the med room for cleanliness, expirations and current supply of medications based on a weekly schedule. to prevent future violations as well as MAR reviews done by the Administrator and her designee on a monthly basis started March 15th 2024

These 7 staff members will not only self monitor themselves but will monitor each other as well on a daily basis. The monitoring step by management will be staff member A, and the staff manager. Weekly monitoring for this regulation will be done by one of these two staff members, and logged on the day and time of their review.

Staff member B will be provide the weekly reports for confirmation of continued weekly monitoring.

Proposed Overall Completion Date: 04/18/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the monitoring indicated in the home's plan of correction is implemented. 4/3/24[redacted]

Directed Completion Date: *04/18/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted] - 5/31/24)

190a - Completion Medication Course

22. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

On 3/9/23 at 9:00 a.m., direct care staff person F administered Levothyroxine 75mcg tablet and Quetiapine 25mg tablet to resident #5, and Ferrous Sulfate 325mg tablet, Finasteride 5mg tablet, Lisinopril 5mg tablet, Pantoprazole SOD 40mg tablet, and Tamsulosin HCL 0.4mg tablet to resident #8. However, direct care staff person F completed the modified medication administration course on 3/21/23 but did not complete the Department-approved medication administration course by 6/30/23.

Plan of Correction ***Accept [redacted] 04/03/2024)***

POC:

190a - Completion Medication Course (continued)

Staff person F and Staff person D as well as 5 other staff were all registered for the same group class, and they all received their certification a few days apart. Staff Person F is the only one that received the wrong certificate from the class. The administrator staff person A was the trainer for course provided through Temple University and all 7 students completed the same class. We are working to get the correct certificate for Staff Person F from Temple and will provide it upon receipt. If we are unable to get the corrected certificate we will retrain Staff Person F.

Upon provision of the correct certificate, we do not believe a POC will be required, but if the department wants something additional, please let us know. We would respectfully request this violation be retracted upon provision of the certificate.

Administrator will monitor her Medication techs and trainees quarterly during the quarterly evaluations starting 03/27/2024

POC revision as requested 3-25-24

All staff certifications will be reviewed quarterly to check for proper certificates, expiration dates, and scheduling any additional training for each staff member. Staff member A with be the responsible for this monitoring,

Staff member B will review the results of the review.

Licensee's Proposed Overall Completion Date: *04/16/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 5/31/24)

225c - Additional Assessment

23. Requirements

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

Description of Violation

Resident #9's annual assessment, dated [redacted]/24, indicated an assessed need for Prostate care, medications as ordered by the doctor daily by direct care staff. However, resident #8's assessment was not updated to include Western PA Home Health Agency as a formal support and did not indicate the resident's use of a foley catheter or the care and services provided by Western PA Home Health Agency related to the care and maintenance of the foley catheter, beginning 9/20/23.

Plan of Correction ***Directed [redacted] - 04/03/2024)***

Home response:

We did not consider this resident to require an updated assessment as a result of any significant changes to their prior assessment, as this was never expressed as being a permanent change in status. The Foley care is not significant if the resident or their POA explains this is temporary and they plan to schedule surgery in the near term to delete the Foley. While this is viewed as not a requirement for a change in assessment, the department can

225c - Additional Assessment (continued)

request that it be a requirement under 225c (3), but this was not requested.

The family and [redacted] treated this as a very causal and temporary situation. Recently we have been advised a surgery is being scheduled to install a permanent drain line into the bladder creating a requirement for a change in assessment. Until this actually happens there is no reason to add this to resident 9's assessment.

The administrator tracks and determines if there are any significant changes to document in conjunction with both house doctors, and visiting care agencies. Neither party advised this was a permanent issue.

We understand that resident 9 filed a complaint that triggered this review of their current assessment. We also understand from the inspectors, the complaint was found to be unsupported.

POC:

While we dispute this violation, we updated the RASP to include the home care agency name and phone number as well as the care provided for Foley care on 3/12/2024. We respectfully request this violation be retracted.

POC revision as requested 3-25-24

Staff member A will be maintaining compliance and is a well educated administrator with 25 plus years of on the job experience and continuing education. [redacted] follows the doctors and medical professionals advise as to when a residents temporary condition should be modified in the residents assessment. She will continue to work with the medical professionals and document any modifications to the residents assessment and who ordered them.

Staff member A will do an audit of all assessments within the next 15 days and submit the results of those assessments to the department.

Monitoring will be done after each scheduled doctor visit to confirm all assessments are current if not covered by the annual assessment. Staff member A will be the completing the monitoring.

Copy of Resident 9 assessment is attached.

Proposed Overall Completion Date: 04/17/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure all resident assessments are updated where there is a change to the resident's care needs and services. 4/3/24 [redacted]

Within 12 calendar days of receipt of the accepted plan of correction: The administrator shall complete the audit indicated in the home's plan of correction. 4/3/24 [redacted]

Directed Completion Date: *04/17/2024*

Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] 5/31/24)

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *SYCAMORE ESTATE PERSONAL CARE RESIDENCE* **License #:** *45450* **License Expiration:** *06/08/2024*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA 15110*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *SYCAMORE ESTATES, LLC*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA, 15110*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/14/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *33* **Waking Staff:** *25*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date:** *05/06/2024*

Inspection Dates and Department Representative

05/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served:** *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *29*

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

Have Mobility Need: *3* **Have Physical Disability:** *0*

Inspections / Reviews

05/06/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/15/2024*

Inspections / Reviews *(continued)*

05/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/23/2024*

05/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/30/2024*

05/31/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/22/2024*

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

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

At approximately 9:40 a.m. there were as many as 50 or more cigarette butts scattered in the brown mulch to the left of the main entrance to the home.

At approximately 10:00 a.m. there were no paper towels or other method to dry hands at the sink of the full bathroom across from the doctor's office, also numbered as Room #4.

At approximately 10:11 a.m. there were no paper towels or other method to dry hands at the sink of the half bathroom in resident room #E-2 belonging to resident #1.

At approximately 10:12 a.m. there were no paper towels or other method to dry hands at the sink of the full bathroom across from resident room #E-1.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Accept [redacted] - 05/20/2024)***

The cigarette butts in the planter have been promptly removed, and to prevent a recurrence, we have installed a bench with corresponding ash cans at the planter entrance. Additionally, we have held individual discussions with each resident who smokes on the premises, emphasizing the sanitary implications of such behavior, especially in light of recent citations. Residents have been issued verbal warnings, with the understanding that further violations may result in a 30-day notice to enroll in smoking cessation programs or adhere strictly to home regulations.

Please refer to the attached photos depicting the cleaned planter area with the newly installed bench and ash cans. Furthermore, we have incorporated both the smoking area and the exterior of our building into our weekly audit checklist, a procedural update highlighted in red text for clarity.

Regarding the occasional empty paper towel dispensers, we maintain a substantial inventory of towels in our dry paper storage area to mitigate such instances. Upon investigation, we found that housekeeping had been adding only one sleeve of towels at a time, resulting in insufficient replenishment. We have instructed both our staff and housekeeping to adopt a more comprehensive approach to dispenser replenishment moving forward.

Attached are photos of three bathrooms illustrating their fully stocked condition. Additionally, this aspect has been added to our weekly audit checklist, denoted in red text for clarity.

Update: 05/16/2024 additional information requested by SW office with a - "Do Not Accept" designation for all 8 items in this LIS.

Please include the staff person (by title) and the date the corrective action was taken.

85a - Sanitary Conditions (continued)

Additional POC: The staff person was the owner and the start date Tuesday, the 7th of May with the removal of all butts, and was completed with the bench and ash cans relocations on May 15, 2024. The photograph's provided were taken on May 15th.

Please include the staff person (by title and the date the audits will begin.

Additional POC: Housekeeping supervisor and the start date is 5/17/24 using the updated audit log that we incorporated our resident smoking area. Copy previously provided.

Please include the education of the staff persons responsible for maintaining compliance with the regulation, including who (by title) completed the education and date the education was completed. Please include documentation of education will be kept in accordance with Regulation 2600.65(i).

Additional POC: All staff (by title) will be re-trained on this regulation at our staff training meeting scheduled for 5/21/24. We will review this specific language of 2000-85a inserted below and include that cigarettes' butts and paper towels are now considered a sanitary condition. Documentation of this training will be kept in the office for department review.

"Sanitary conditions" can include many different situations in a personal care home. While unsanitary conditions will often be determined on a case-by-case basis, they generally include the following:

- *Feces, human or animal*
- *Urine, human or animal*
- *Bodily fluids, such as blood, mucus, vomit, or semen*
- *Rotten or spoiled foods*
- *The presence of mold or mildew*
- *Pungent odors*
- *Extremely unclean surfaces*

Please include the specific correction to the violation. including what correction was made, who (by title) completed the corrective action, and the date the corrective action was completed. Related to each of the paper towel violations.

Additional POC: Paper towels were install in bathroom E, Shower room East up, and resident rooms E1, and E2. The housekeeping supervisor did the corrective action, and the date of corrective action was 5/6/24, the day of the reinspection of our annual inspection conducted on March 11, 2024. All four violations were corrected within 5 minutes.

Our previous POC is still part of our response herein. We attached an updated audit template to include these items for our weekly inspection's.

85a - Sanitary Conditions (continued)

Licensee's Proposed Overall Completion Date: *05/21/2024* Implemented [redacted] - 6/6/24)
Licensee's Proposed Date for POC Implementation

141a 1-10 Medical Evaluation Information

2. Requirements

2600.
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 2's initial medical evaluation, dated [redacted]/24, indicated "see attached" for medications, however, there was nothing attached to the medical evaluation form.

Resident #2's initial medical evaluation, dated 3/5/24, was missing resident vitals information to include weight, pulse rate, temperature, and blood pressure, those areas of the medical evaluation form were left blank.

Plan of Correction ***Accept[redacted] - 05/20/2024)***

The medical assessment for Resident 2 indicated that the medication list was to be referenced in an attached document. However, the initial transmission from the placement agency lacked this attachment, which was subsequently provided in a separate email and has now been appended to the resident's chart.

Furthermore, it was noted that the replacement DME conducted within the facility was performed by [redacted] This matter will be addressed and finalized during [redacted] upcoming visit on 05/15/2024.

In order to ensure comprehensive oversight, the administrator and their appointed representative will undertake additional monitoring of all physician orders and discharge directives received from previous facilities prior to their integration into resident charts.

Moreover, the medication list supplied by the Skilled facility, Southwestern, has been included as an attachment.

141a 1-10 Medical Evaluation Information (continued)

5-16- 24 Additional request:

Please include the specific correction to the violation. including what correction was made, who (by title) completed the corrective action, and the date the corrective action was completed. For each resident.

This matter was resolved and concluded during [redacted] visit on May 15, 2024. A new and comprehensive DME has been verified and added to the resident's chart for departmental review.

Please include the education of the staff persons responsible for maintaining compliance with the regulation, including who (by title) completed the education and date the education was completed. Please include documentation of education will be kept in accordance with Regulation 2600.65(i).

On May 13, 2024, the administrator retrained their designee on the proper completion of DME documents and their placement in residents' charts. Documentation of this training is on file in the office for departmental review.

Please include an audit of all current resident medical evaluations for accuracy and completeness, including who (by title) completed the audit, and the date the audit will be completed.

The audit of all current resident DMEs will be completed by the Administrator and her designee by May 21, 2024. Documentation of this audit will be on file in the office for departmental review.

Please include an audit of all newly completed resident medical evaluations for accuracy and completeness, including who (by title) will complete the audit, and the date the audit will be begin

An audit of the newly completed DMEs by [redacted] on May 15, 2024, was conducted by the Administrator and [redacted] designee. These documents were subsequently placed in the residents' charts for departmental review on the same day.

Licensee's Proposed Overall Completion Date: *05/21/2024* Not Implemented [redacted] - 5/31/24)
Licensee's Proposed Date for POC Implementation

183e - Storing Medications

3. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

At approximately 1:00 p.m. there was a 40-caplet generic pill bottle of Stomach Relief or Bismuth 262mg Chew tablet in the clear plastic bin that belonged to resident #2 that indicated an expiration date of 1/2024.

183e - Storing Medications (continued)

At approximately 1:00 p.m. there was a 100-caplet generic pill bottle of Pain Relief or Acetaminophen 500mg tablets in the clear plastic bin that belonged to resident #2 that indicated an expiration date of 10/2021.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Accept [redacted] 05/20/2024)***

All medications provided by families will undergo thorough assessment through the office, with the following criteria:

1. Verification of approval from the Primary Care Physician (PCP) along with written prescriptions for pharmacy-dispensed medications.

2. Examination of expiration dates to ensure medication viability.

3. Confirmation of sealed bottles for over-the-counter (OTC) medications.

Upon meeting these requirements, medications will be accurately documented and integrated into the Medication Administration Record (MAR).

A memorandum detailing these procedural adjustments, signed by all staff members, has been distributed to ensure awareness. Implementation of this protocol by staff is expected to be completed on or before 05/21/2024.

5-16- 24 Additional request:

Please include the specific correction to the violation. including what correction was made, who (by title) completed the corrective action, and the date the corrective action was completed. For each resident.

All OTC and outside medications were checked by the administrators designee according to the previously established criteria.

Medications provided by families will undergo thorough assessment through the office, based on the following criteria:

1. Verification of approval from the Primary Care Physician (PCP) along with written prescriptions for pharmacy-dispensed medications.

2. Examination of expiration dates to ensure medication viability.

3. Confirmation of sealed bottles for over-the-counter (OTC) medications.

These specific medication checks were completed on 05/09/2024 and the documentation of this is in the office for review. The medications in question were replaced with current medications from the pharmacy, and the families were notified.

183e - Storing Medications (continued)

Upon meeting these requirements, medications will be accurately documented and integrated into the Medication Administration Record (MAR).

Please include the education of the staff persons responsible for maintaining compliance with the regulation, including who (by title) completed the education and date the education was completed. Please include documentation of education will be kept in accordance with Regulation 2600.65(i).

A memorandum detailing these procedural adjustments, signed by all staff members, has been distributed to ensure awareness. Implementation of this protocol by staff is expected to be completed on or before 05/21/2024. Copy of signed memorandum will be provided to the department.

All staff will be retrained on this regulation on 05/21/2024. Documentation of the training will be in the office for department review.

Please include an audit of all resident medications to ensure compliance with Regulation 2600.183(e), including who (by title) completed the audit, and the date the audit will be completed.

An audit of all resident medications to ensure compliance with Regulation 2600.183(e), by the administrator and her designee will be completed by 05/21/2024. Documentation of the audits will be kept in the office for department review.

Please include a biweekly audit of all resident medications for to ensure compliance with Regulation 183(e), including who (by title) will complete the audit, and the date the audit will be begin.

A biweekly audit of all resident medication to ensure compliance with Regulation 2600.183(e) will be done by the administrator and her designee. These audits will be begin on 05/26/2024. Documentation of the audits will be kept in the office for department review.

Licensee's Proposed Overall Completion Date: *05/21/2024* Not Implemented [redacted] - 5/31/24)
Licensee's Proposed Date for POC Implementation

184a - Resident's Meds Labeled

4. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for resident #3's Dorzolamide HCL/Timolol Maleate Op 22.3-6.8mg/mL Solution indicated "instill 1 drop into both eyes 2 times every day." However, resident #3 is prescribed Dorzolamide HCL/Timolol Maleate Op

184a - Resident's Meds Labeled (continued)

22.3-6.8mg/mL Solution, instill 1 drop into both eyes 1 time every day.

REPEAT VIOLATION 9/19/23

Plan of Correction ***Accept [redacted]05/20/2024)***

Please refer to the attached documentation, which includes new orders from [redacted]an updated medication list, and a revised Medication Administration Record (MAR) reflecting the updated orders dated 05/08/2024, coinciding with their reception and reinstatement.

Training sessions for all Medication Technicians are scheduled for 05/21/2024. These sessions will encompass a comprehensive review of documentation procedures and thorough examination of MAR checks.

Please find further details in the attached addendum.

5-16- 24 Additional request:

Please include the specific correction to the violation. including what correction was made, who (by title) completed the corrective action, and the date the corrective action was completed.

To address this situation, the following plan of action has been developed and implemented as of 05/06/2024:

1. ***Smart Program Access***: The designated individual has been granted access to the Smart Program to approve new medications entered by Health Direct. This was completed on 05/06/2024.

2. ***Retraining on Paper MARs:*** All medication staff will undergo retraining on the use of alternative paper Medication Administration Records (MARs). Blank MARs for each resident were printed from Tabula Pro for future use. This retraining is scheduled for 05/13/2024.

3. ***Retraining on Discharge Paperwork Assessment:*** The medication team will be retrained on the proper assessment of discharge paperwork. This session will take place on 05/21/2024, as outlined in the attached agenda, and will be conducted by the administrator.

Additional Actions:

- The medication was refilled and properly labeled, with the MAR documentation correctly updated.

- The MAR for the resident was amended on 05/08/2024 by the designee, who accessed the SMART program and responded to the prompt to add the medication. Documentation of this update has been previously submitted to the department.

184a - Resident's Meds Labeled (continued)

Please include the education of the staff persons responsible for maintaining compliance with the regulation, including who (by title) completed the education and date the education was completed. Please include documentation of education will be kept in accordance with Regulation 2600.65(i).

The staff member designated to assist in updating MAR additions from Pharmacy Health Direct is the administrator's designee. [redacted] was granted "admin" access in the SMART app to enable [redacted] to perform these updates. This was completed on 05/06/2024 by the administrator. Documentation of the education will be maintained in accordance with Regulation 2600.65(i).

Please include an audit of all resident medications to ensure compliance with Regulation 2600.184(a), including who (by title) completed the audit, and the date the audit will be completed.

An audit of all resident Medication Administration Records (MARs) to ensure compliance with Regulation 2600.184(a) will be conducted by the administrator and her designee. This audit will be completed by 05/21/2024. Documentation of the audits will be maintained in the office for department review.

Please include a biweekly audit of all resident medications for to ensure compliance with Regulation 184(a), including who (by title) will complete the audit, and the date the audit will be begin.

A biweekly audit of all resident Medication Administration Records (MARs) to ensure compliance with Regulation 2600.184(a) will be conducted by the administrator and her designee. The audit will begin on 05/26/2024. Documentation of these audits will be maintained in the office for department review.

Licensee's Proposed Overall Completion Date: *05/21/2024* Not Implemented [redacted] - 5/31/24)
Licensee's Proposed Date for POC Implementation

187a - Medication Record

5. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

187a - Medication Record *(continued)*

10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #2's medication administration record for May 2024 did not include an area to document the administration of the medication Celecoxib 100mg capsule. However, resident #2 is prescribed Celecoxib 100mg capsule, take one capsule by mouth two times a day.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Accept ([redacted]- 05/20/2024)***

Following discharge, medications transmitted electronically to our pharmacy are processed and dispatched to the facility. This medication was not transmitted by the facility to the pharmacy but by the hospital during discharge. Adherence to the Smart program mandates administrator approval for these medications is required. However, on 04/30/2024, upon arrival of the medication in question at the facility, the administrator was absent due to a fall resulting in a right arm fracture on 04/26/2024. Consequently, administration of this medication occurred without corresponding documentation in the MAR.

To rectify this situation, the following plan of action has been devised:

1. Granting access to the Smart Program for medication approval to a designated staff member. This delegation was completed on 05/06/2024.

2. Conducting retraining sessions for all medication staff on the utilization of alternate paper MARs. These documents, sourced blank for each resident from Tabula Pro, were distributed for future use on 05/13/2024.

3. Reinforcing the proper assessment of discharge paperwork through retraining of the Medication team.

Retraining sessions are scheduled for 05/21/2024, with the attached agenda providing details. The administrator will oversee these sessions. Copies of the training materials and the sign-in sheet will be maintained in the office for reference and review.

Attached is a copy of the blank paper MAR which was added to our staff documents for their use.

5-16- 24 Additional request:

Please include the specific correction to the violation. including what correction was made, who (by title) completed the corrective action, and the date the corrective action was completed.

187a - Medication Record (continued)

As per our previous documentation, the following plan of action has been devised and implemented on 05/06/2024 to rectify this situation:

*1. **Smart Program Access:** The designee has been granted access to the Smart Program to approve new medications entered by Health Direct. This was completed on 05/06/2024.*

***Retraining on Paper MARs:** All medication staff will be retrained on the use of alternate paper Medication Administration Records (MARs). Blank MARs for each resident were printed from Tabula Pro for future use. This retraining is scheduled for 05/13/2024.*

*3. **Retraining on Discharge Paperwork Assessment:** The medication team will be retrained on the proper assessment of discharge paperwork. This retraining is scheduled for 05/21/2024, as detailed in the attached agenda, and will be conducted by the administrator.*

Additionally, the MAR for the resident was corrected on 05/06/2024 by the administrator, who accessed the SMART program and addressed the prompt to add the medication. Documentation of this update has been previously submitted to the department.

Please include the education of the staff persons responsible for maintaining compliance with the regulation, including who (by title) completed the education and date the education was completed. Please include documentation of education will be kept in accordance with Regulation 2600.65(i)

The staff person designated to assist in updating MAR additions from Pharmacy Health Direct is the administrator's designee. [redacted] was added to the SMART app as an "admin" to enable [redacted] to perform these updates. This was completed on 05/06/2024 by the administrator. Documentation of the education will be maintained in accordance with Regulation 2600.65(i).

Please include an audit of all resident medications administration records to ensure compliance with Regulation 2600.187(a), including who (by title) completed the audit, and the date the audit will be completed.

An audit of all resident Medication Administration Records (MARs) to ensure compliance with Regulation 2600.187(a) will be conducted by the administrator and her designee. This audit will be completed by 05/21/2024. Documentation of the audits will be maintained in the office for department review.

Please include a biweekly audit of all resident medication administration records to ensure compliance with Regulation 187(a), including who (by title) will complete the audit, and the date the audit will be begin.

A biweekly audit of all resident Medication Administration Records (MARs) to ensure compliance with Regulation 2600.187(a) will be conducted by the administrator and her designee. The audit will begin on 05/26/2024. Documentation of these audits will be maintained in the office for department review.

Licensee's Proposed Overall Completion Date: *05/21/2024* Not Implemented [redacted] - 5/31/24)
Licensee's Proposed Date for POC Implementation

187b - Date/Time of Medication Admin.

6. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed Celecoxib 100mg capsule, take one capsule by mouth two times a day. However, on dates ranging from 4/30/24 through 5/6/24, resident #2 was administered the Celecoxib 100mg capsule and it was not documented at the time of administration on the May 2024 medication administration record.

REPEAT VIOLATION 9/19/23, 6/22/23 et. al.

Plan of Correction ***Accept ([redacted] 05/20/2024)***

Medications entering the home post discharge that are sent electronically to our pharmacy are filled and sent to the facility. The Smart program requires the administrator to enter an approval of the medication. The medication in question arrived in the facility 04/30/2024 and the administrator was out of the facility due to a fall with [redacted] the right arm on 04/26/2024 This medication was given and the mar did not reflect this .

To rectify this situation, the following plan of action has been devised:
1. have the designee given accesses to Smart Program to approve the new medications entered by Health Direct this was done on 05/06/2024.
2. Retrain all medication staff on alternate paper MARS these were printed blank for each resident from Tabulapro for future use 05/13/2024
3. Retraining the Medication team on proper assessment of discharge paperwork.
Retraining will occur 05/21/2024 see agenda attached. This training will be given by the administrator

Copies of the training and sign in sheet will be kept in the office for review.

5-16- 24 Additional request:

Please include the specific correction to the violation. including what correction was made, who (by title) completed the corrective action, and the date the corrective action was completed. Was the MAR corrected?

In accordance with our previous documentation, the following plan of action was formulated and executed on 05/06/2024 to address the situation:

*1. **Smart Program Access:** The designee was granted access to the Smart Program to approve new medications entered by Health Direct. This task was completed on 05/06/2024.*

*2. **Retraining on Paper MARs:** All medication staff underwent retraining on the use of alternate paper Medication Administration Records (MARs). Blank MARs for each resident were printed from Tabula Pro for future use. This retraining session took place on 05/13/2024.*

*3. **Retraining on Discharge Paperwork Assessment:***

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

The Medication team received retraining on the proper assessment of discharge paperwork. This training session is scheduled for 05/21/2024, as indicated in the attached agenda. The administrator will conduct this training.

Furthermore, the MAR for the resident was corrected on 05/06/2024 by the administrator. The correction was made by accessing the SMART program and responding to the prompt to add the medication. Documentation of this update was previously submitted to the department.

Please include the education of the staff persons responsible for maintaining compliance with the regulation, including who (by title) completed the education and date the education was completed. Please include documentation of education will be kept in accordance with Regulation 2600.65(i).

The staff member designated to assist in updating MAR additions from Pharmacy Health Direct is the administrator's designee. [redacted] was added to the SMART app as an "admin" to facilitate these additions, a process completed by the administrator on 05/06/2024. Documentation of the education will be maintained in accordance with Regulation 2600.65(i).

Please include an audit of all resident medications administration records to ensure compliance with Regulation 2600.187(b), including who (by title) completed the audit, and the date the audit will be completed.

An audit of all resident medication administration records to ensure compliance with Regulation 2600.187(b) will be conducted by the administrator and [redacted] designee. This audit will be completed by 05/21/2024. Documentation of the audits will be retained in the office for departmental review.

Please include a biweekly audit of all resident medication administration records to ensure compliance with Regulation 187(b), including who (by title) will complete the audit, and the date the audit will be begin.

A biweekly audit of all resident medication administration records to ensure compliance with Regulation 187(b), By the administrator and [redacted] designee will complete the audit, and the audit will be begin on 05/26/2024. Documentation of the audits will be kept in the office for department review.

Licensee's Proposed Overall Completion Date: *05/21/2024*

Not Implemented [redacted] - 5/31/24)

Licensee's Proposed Date for POC Implementation

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #2 is prescribed Polyethylene Glycol Powder indicated "Mix 17 grams (one capful) in 8 ounces of water and drink daily." However, resident #2's May 2024 medication administration record indicated the prescriber's order "as needed", and the Polyethylene Glycol Powder was not administered daily to resident #2.

187d - Follow Prescriber's Orders (continued)

REPEAT VIOLATION 2/1/24, 9/19/23, 6/22/23 et. al.

Plan of Correction ***Accept[redacted] - 05/20/2024)***

Medications received post-discharge and electronically sent to our pharmacy are processed and dispatched to the facility. Compliance with the Smart program necessitates administrator approval for these medications. However, a discrepancy arose regarding a change in dosage from PRN to Daily, which occurred at discharge from the hospital. Although the discharge paperwork was reconciled with the MAR and new medications were duly added and documented, this specific medication change was overlooked during review, as it was not flagged as changed by the hospital.

To address this issue, the following plan of correction has been established:

1. Grant designated staff access to the Smart Program for approving new medications entered by Health Direct. This action was completed on 05/06/2024.

2. Conduct retraining sessions for all medication staff on utilizing alternate paper MARs. Blank MARs for each resident were printed from Tabula Pro for future use on 05/13/2024. Retraining is scheduled for 05/21/2024, details of which are provided in the attached agenda.

3. Implement retraining on discharge reconciliation for medications, treatments, and follow-up appointments during the 05/21/2024 training session, led by the administrator. Refer to the attached agenda for further details.

Copies of the training materials and sign-in sheet will be maintained in the office for reference and review.

Furthermore, confirmation of the medication in question, Poly Ethylene Glycol, was obtained from [redacted] and the MAR was accordingly updated. Please refer to the attached paperwork for documentation.

See Doctor's orders attached to clarify these two items.

5-16- 24 Additional request:

Please include the (Administrator, Director of Wellness, Certified Medication Administration Trainer, Certified Medication Administration Observer, designated staff person) shall observe each staff responsible for medication administration. Each staff will be observed once per week for a period of (three) months. After which, each staff will be observed once per month for a period of (three) months, Including the start date of the observations. Please include documentation of the observations shall be maintained by the home for Department review.

The Administrator, certified as a Medication Administration Trainer, will observe each staff member responsible for medication administration. Each staff member will be observed once per week for a duration of three months, starting from 05/20/2024 through August. Subsequently, each staff member will be observed once per month for a duration of three months through November. The observation period commences on 05/20/2024. Documentation of these observations will be maintained in the office for departmental review.

187d - Follow Prescriber's Orders (continued)

Please include a daily audit of all resident MARs to ensure the orders of the prescribers are followed, including who (by title) will complete the audits, and the date the audit will begin.

We cannot commit to daily audits of all resident MARs to ensure the orders of the prescribers are followed, The administrator and her designee will complete the audits biweekly, and the audit will begin 05/20/2024. Documentation of the audits shall be maintained in the office, by the home for Department review. If this is a concern then we need to discuss by phone.

Please include notifying the resident and the resident's designated person of the medication error. Including who made (by title) the notification and the date when the notification was made.

The resident and their designated representative were informed about the medication error by the administrator on 05/17/2024.

Please include notifying the prescriber of the medication error, including who made (by title) the notification and the date when the notification was made. Also indicate the home shall follow the direction of the prescriber related to the medication error.

The prescriber of the medication, [redacted] was notified of the error on 05/06/2024 via fax. Clarification of the orders was requested and obtained from him, and these clarifications were implemented on 05/08/2024 as per the documents previously submitted. This process was facilitated by the administrator and her designee.

Please include filing an incident report for the medication error including who made (by title) the notification and the date when the notification was made.

The home will adhere to the directives provided by the prescriber regarding the medication error.

An incident report for the medication error was submitted to the department by the administrator on 05/17/2024. The notification of the incident was previously attached to our 1st POC submission.

Please indicate the medications error was made part of the resident's permanent record error including who made (by title) completed updating the resident's record and the date when the record was updated.

The administrator has placed a copy of the incident report in the resident's permanent chart. This documentation is available in the office for departmental review.

Licensee's Proposed Overall Completion Date: *05/21/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] 5/31/24)

190a - Completion Medication Course

8. Requirements

2600.

190a - Completion Medication Course *(continued)*

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Direct care staff person A's medication administration training was dated 3/14/23 and the documentation of annual practicum and observations conducted was incomplete. Direct care staff person A has administered medications to residents of the personal care home as follows:

Resident #2:

- *Alendronate 70mg on 5/1/24 at 8:00 a.m.*
- *Amlodipine 5mg on 5/1/24, 5/2/24, and 5/6/24 at 9:00 a.m.*
- *Gabapentin 300mg capsule on 5/1/24 and 5/2/24 at 9:00 a.m., 2:00 p.m., and 9:00 p.m.*
- *Lacosamide 150mg tablet on 5/1/24 and 5/2/24 at 9:00 a.m. and 9:00 p.m.*
- *Pantoprazole SOD 40mg tablet on 5/1/24 and 5/2/24 at 9:00 a.m.*

Resident #3:

- *Aspirin EC 81mg tablet on 5/3/24 and 5/5/24 at 7:00 a.m.*
- *Carvedilol 25mg tablet on 5/2/24 at 7:00 p.m., 5/3/24 at 7:00 a.m. and 7:00 p.m., and 5/5/24 at 7:00 a.m.*
- *Chlorthalidone 25mg tablet on 5/3/24 and 5/5/24 at 7:00 a.m.*
- *Clonidine HCL 0.1mg tablet on 5/2/24 at 7:00 p.m., 5/3/24 at 7:00 a.m. and 7:00 p.m., and 5/5/24 at 7:00 a.m.*
- *Fish Oil 1,000 Soft gel Capsule on 5/3/24 and 5/5/24 at 7:00 a.m.*

Resident #4:

- *Amlodipine Besylate 2.5mg tablet from 5/2/24 through 5/6/24 at 8:00 a.m.*
- *Acetaminophen 500mg caplet from 5/2/24 through 5/5/24 at 9:00 a.m. and 2:00 p.m., and 5/6/24 at 9:00 a.m.*
- *Levothyroxine 75mcg tablet from 5/2/24 through 5/6/24 at 9:00 a.m.*
- *Quetiapine 25mg tablet from 5/2/24 through 5/6/24 at 9:00 a.m.*
- *Senna-Time 8.6mg tablet from 5/2/24 through 5/6/24 at 9:00 a.m.*

Plan of Correction ***Directed [redacted] 05/20/2024)***

Regarding Direct Care Staff person A, who serves as our designee and possesses nine years of experience as a medication technician within our facility, quarterly observations were conducted up to January 2024. Subsequently, the trainer, [redacted] completed her annual observations on 05/10/2024.

All relevant training materials are attached.

Furthermore, the documentation of all medication technicians has been thoroughly reviewed by both the administrator and Staff person A. On 05/13/2024, it was confirmed that they are in compliance with the required standards. Documentation for all training sessions is accessible for review in the office.

Update: Per [redacted]

190a - Completion Medication Course (continued)

05/16/2024

Please include a monitoring step including the date the monitoring will start, what is being monitored, the frequency of the monitoring, and who (by title) will be completing the monitoring.

Monitoring started on 05/13/2024 will include review of Quarterly observations with MAR review for all Medication Tech, this will occur Monthly and be done by administrator who is a certified medication administration trainer. Documentation of these audits will be kept in the office for department review.

Proposed Overall Completion Date: 05/18/2024

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all records of staff persons administering medications on a quarterly basis to ensure all staff persons administering medications are qualified to administer medications and continue to be qualified to administer medications. 5/20/24 J[redacted]

Directed Completion Date: *05/21/2024*

Licensee's Proposed Date for POC Implementation

Not Implemented[redacted] - 5/31/24)