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

September 18, 2024

[redacted], REGIONAL CLINICAL SUPPORT SPECIALIST
COUNTRYSIDE CONVALESCENT HOME LIMITED PARTNERSHIP
8221 LAMOR ROAD
MERCER, PA, 16137

RE: QUALITY LIFE SERVICES MERCER
8221 LAMOR ROAD
MERCER, PA, 16137
LICENSE/COC#: 45029

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/09/2024, 05/16/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *QUALITY LIFE SERVICES MERCER* **License #**: *45029* **License Expiration**: *07/07/2024*

Address: *8221 LAMOR ROAD, MERCER, PA 16137*

County: *MERCER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRYSIDE CONVALESCENT HOME LIMITED PARTNERSHIP*

Address: *8221 LAMOR ROAD, MERCER, PA, 16137*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/04/2003* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/16/2024*

Inspection Dates and Department Representative

05/09/2024 - On-Site: [redacted]

05/16/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *26*

Special Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *26*

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

Have Mobility Need: *9* **Have Physical Disability**: *1*

Inspections / Reviews

05/09/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/03/2024*

06/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/19/2024*

Inspections / Reviews *(continued)*

06/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/03/2024*

09/18/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/02/2024*

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

65a Fire Safety-1st day

1. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Direct care staff A, hired [redacted], did not receive training required trainings on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable. the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, Smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Direct staff person A, was terminated by the Administrator at QLS Mercer effective [redacted] due to not meeting the required attendance standards.

Effective 6/5/2024 the PC administrator and or designee will ensure that all current direct care staff including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that include the following:

Evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable. The designated meeting place outside the building or within the fire- safe area in the event of an actual fire, Smoking safety procedures, the homes smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services. This audit will be completed by the PC Administrator and or designee completed by 6/5/2024 any employee who is out of compliance will immediately be receiving the education needed to be compliant with regulation 2800.65a

The PC Administrator and or designee will ensure that all direct care staff are trained on the first day of hire for all procedures listed above. Effective date of 5/17/2024
The PC Administrator has educated Human Resources along with the Wellness Director on the importance of this orientation on 5/17/2024. Documentation of the education will be kept.

Effective 6/5/2024 audits will be completed on every new hire to ensure that each new hire has training on the first day of work for all listed above requirements. Audits will be completed, reviewed and recorded in the monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

65e Rights/Abuse 40 Hours

2. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Direct care staff A, hired [redacted], did not receive training required trainings on the following topics: Resident rights. 2. Emergency medical plan., mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, Reporting of reportable incidents and conditions, Safe management techniques, Core competency training that includes the following: Person-centered care, Communication, problem solving and relationship skills, Nutritional support according to resident preference.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Direct staff person A, was terminated by the Administrator at QLS Mercer effective [redacted] due to not meeting the required attendance standards.

Effective 6/5/2024 the PC administrator and or designee will ensure that all current direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation within 40 scheduled working hours that includes the following: This will be completed 6/5/2024

Emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, reporting of reportable incidents and conditions, problem solving and relationship skills, Nutritional support according to resident preference. Any current employee found out of compliance the PC Administrator or designee will provide the education needed to be compliant with regulation 2800.65e

The PC administrator has educated Human Resources along with the Wellness Director on the importance of this orientation on 5/17/2024. Documentation of the education will be kept.

Effective 6/5/2024 audits will be completed by the PC Administrator and or designee on every new hire to ensure that each new hire has training within 40 scheduled working hours. Audits will be completed weekly for 4 weeks and ending on 7/3/2024. Results of audits will be reviewed and recorded to monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

65h 16 hrs annual training

3. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

65h 16 hrs annual training *(continued)*

Description of Violation

Direct care staff B, hired [redacted] received 12.5 hours of annual training during the January 2023 through December 2023 training year.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Effective 6/5/2024 direct care staff person B, shall have at least 16 hours of annual training provided by the Administrator and Health Stream relating to their job duties. The training required in 2800.69(relating to additional dementia- specific training) shall be in addition to the 16 hour annual training. Training completed by 7/3/2024 documentation of the education will be kept.

The PC administrator has educated Human Resources along with the Wellness Director on the importance of annual training completion on 5/17/2024. The PC Administrator and or designee will conduct an audit of current employees to ensure they meet the education requirements for regulation 2800.65.h. audit will be completed by 7/3/2024.

Effective 6/5 /2024 PC Administrator and Human Resources will audit 5 random employee files to ensure direct care staff person will have 16 hours of annual training related to job duties and additional dementia training. .This training will be added to our Health stream education. Audits will be completed quarterly by PC Administrator and or designee along with Human Resources. Results of audits will be reviewed and recorded to monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

65i Training topics

4. Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Assisted living service needs of the resident.

Description of Violation

Direct care staff B, hired [redacted], did not complete trainings during the January 2023 through December 2023 training year in the following content areas: Medication self administration, instruction on meeting the needs of the residents, assisted living service needs of the resident.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Effective 6/5/2024 direct care staff B, shall have annual training provided by Administrator and Health Stream for current direct care staff persons including the following:

1. Medication self-administration training.

2. Instructions on meeting the needs of the resident as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

3. Assisted living service needs of the resident.

65i Training topics (continued)

Completion of the training by 7/3/2024 conducted by the Administrator and/or designee. Documentation of this education will be kept.

The PC administrator has educated Human Resources along with the Wellness Director on the importance of annual training and maintaining of records on 5/17/2024. Documentation of this education will be kept.

Effective 6/5 /2024 PC Administrator and Human Resources will audit 5 random employee files to ensure direct care staff person will have 16 hours of annual training related to job duties and additional dementia training. Audits will be completed weekly for 4 weeks and ending on 7/3/2024 the results of the audit will be reviewed and recorded in the monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

65j Annual training content

5. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Direct care staff B, hired [redacted] did not complete trainings during the January 2023 through December 2023 training year in fire safety conducted by a fire safety expert and emergency preparedness.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Effective 6/5/2024 direct care staff persons, ancillary staff persons, substitute staff personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by the fire safety expert are acceptable for the training if accompanied by and outside person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crisis and emergency situations.

The Administrator has ensured that Direct care staff B, has completed fire safety on 5/17/2024 by a fire safety expert. The documentation of this education will be kept.

Effective 6/5/2024 the PC Administrator and or designee will provide the education to all current direct staff to be compliant with the regulation 2800.65.j. The documentation of the education will be kept.
The PC administrator has educated Human Resources along with the Wellness Director on the importance of annual fire safety and emergency preparedness training on 5/17/2024. The documentation of this education will be kept.

Effective 6/5 /2024 PC Administrator and Human Resources will audit 5 random employee files to ensure direct

65j Annual training content (continued)

care staff person will have annual fire safety and emergency preparedness training. Audits will be completed quarterly. The results of audits will be reviewed and recorded in the monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 09/13/2024)

81b Resident equip – good repair

6. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 5/9/24, there were two enablers attached to resident #1's bed in bedroom # The enabler on the right side was not secured to the bedframe and moved back and forth approximately 2 to 3 inches. Then enabler was uncovered and had an open area measuring 12 ½ inches by 16 ½ inches between the posts and there was a 4 inch space between the posts and the mattress.
The enabler on the left side was covered, however it was not secured to the bedframe and moved back and forth approximately 1 to 2 inches and there was a 2 inch space between the enabler posts and the mattress.

Plan of Correction ***Accept (- 06/25/2024)***

The facility will ensure that wheelchairs, walkers, prosthetic devices and other apparatus used by residents will be clean, in good repair and free of hazards.

Two enablers attached to resident #1's bed in bedroom # . Enabler on the right side not secured to bed frame and uncovered. Enabler to the left was covered and not secured to the bed frame.

The enabler bars from bed frame in room # were removed immediately by maintenance department on 5/9/2024.

An audit performed by the PC Administrator was completed on 5/9/2024 of all other resident rooms to ensure there were no other enabler bars present. Any found were immediately removed.

Education was provided by the PC Administrator to the AL staff on the department's regulation 2800.81.b on 5/10/2024 and 5/11/2024. Documentation of the education will be kept.

A weekly audit will be performed by the PC Administrator or designee to ensure no enabler bars are being used. If any are found the audit will ensure they meet department's regulation 2800.81.b. This audit will begin on 6/5/2024 and end 7/3/2024. The results of the audit will be reviewed and recorded in the monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 09/13/2024)

95 Furniture & Equipment

7. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 5/9/24, the plastic towel rack next to the toilet in bedroom #35 was broken and had a crack measuring approximately 4 inches with a sharp edge, creating a potential skin tear hazard.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

The facility will ensure that furniture and Equipment must be in good repair, clean and free of hazards.

Administrator ensured the towel rack in bedroom #35 was replaced by the maintenance department immediately on 5/9/2024.

An audit of all residents' rooms was conducted by the PC Administrator to ensure no other towel racks were in violation of the department's regulation 2800.95. Any found in violation were immediately replaced on 5/9/2024The Pc Administrator provided education to the AL staff along with maintenance department on the importance and requirements of regulation 2800.95. On 5/9/2024. Documentation of the education will be kept.

The Pc Administrator provided education to the AL staff along with maintenance department on the importance and requirements of regulation 2800.95 on 5/9/2024. Documentation of the education will be kept.

Effective 6/5/2024 weekly room inspection will be performed by the PC Administrator or designee of all residents' bathrooms to ensure compliance with the department's regulation of 2800.95 ending on 7/3/2024. Maintenance will then conduct a monthly room inspection to ensure compliance.

Results of the audits and inspections will be reviewed and recorded in the monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

105g Dryer lint removal

8. Requirements

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 5/9/24, there was a layer of lint, measuring approximately 1/8 inch thick, and an accumulation of lint on the floor of the lint trap in dryer #1 and #2 in the laundry area. According to staff interviews, the lint traps are not cleaned between each load.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

The lint traps in dryers 1 and 2 were immediately cleaned by Maintenance. This was completed on 5/9/2024, all

105g Dryer lint removal (continued)

other dryers in the facility were immediately cleaned by maintenance to ensure they met the requirements of the departments' regulation 2800.105g on 5/9/2024.

PC Administrator educated laundry staff on the departments' regulation and the importance of cleaning the lint trap after each use on 6/5/2024.Documentation of the education will be kept. The PC Administrator placed reminder signs around dryer area to clean dryer lint trap after each use on 6/5/2024.

A daily audit of the dryer's lint traps will be performed by the PC admin or designee 5 times a week for four weeks to ensure compliance. The audits will begin on 6/5/2024 and end on 7/3/2024.

Results of the audits will be reviewed and recorded in the monthly QAPI meeting beginning on June 19th, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

132a Monthly fire drill

9. Requirements

2800.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of September 2023.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

An unannounced fire drill was not held during the month of September 2023.

On 5/17/2024 the administrator educated the maintenance director on the importance of regulation 2800.132.a. and compliance. Documentation of the education will be kept.

The administrator will ensure audits are completed monthly for 3 months starting 6/1/2024 and ending 9/1/2024 to ensure the maintenance department has held an unannounced monthly fire drill. Results of the audits will be reviewed and recorded in the monthly QAPI meeting held on June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

132b Safety inspection/fire drill

10. Requirements

2800.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection was conducted on 2/9/24. However, the previous inspection was conducted on 1/17/23.

132b Safety inspection/fire drill *(continued)*

Plan of Correction ***Accept ([redacted] - 06/28/2024)***

PC Admin immediately scheduled a fire safety inspection on 02/09/2024.

The NHA provided education to the PC Admin, Maintenance Director and the AL staff on the importance of and the requirements of the department's regulation 2800.132.b on 06/05/2024 Documentation of the education will be kept.

PC Administrator scheduled the annual fire safety inspection for January will ensure the yearly fire safety inspections happen within the guidelines of the departments

The education and importance of the departments regulation 2800.132.b will be reviewed and recorded in the monthly QAPI meeting June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

132c Fire drill records

11. Requirements

2800.
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 residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill record does not include the year for the fire drills conducted on 6/8, 7/27, 8/10, 9/19, 10/10. 11/14. 12/30 and 4/20. It does not indicate the time of the fire drill in hours and minutes conducted on 11/14 and does not indicate a.m. or p.m. for the drill conducted on 4/11/23.

Plan of Correction ***Accept ([redacted] - 06/28/2024)***

PC Admin immediately verified and added the complete date to the fire drill book for the dates that were not in compliance with the department's regulation of 2800.132.c on 05/17/2024. The PC Administrator verified with the Maintenance Director the hours and minutes the fire drill was conducted on 11/14/23 along with the am or pm. This was added to the fire drill documentation on 11/14/23.

PC Admin provided education to the maintenance director on the requirements and the importance of the department's regulation 2800.132.c on 6/5/2024. Documentation of the education will be kept.

A monthly audit will be completed by the PC admin or designee on the complete documentation of the fire drills for 3 months beginning 6/5/2024 and ending 9/5/2024 to ensure compliance with the regulation 2800. 132.c

Results of the audits will be reviewed and recorded in the monthly QAPI meeting June 19, 2024

Licensee's Proposed Overall Completion Date: *07/03/2024*

132c Fire drill records *(continued)*

Implemented ([redacted] - 09/13/2024)

132f Alternate exit routes

12. Requirements

2800.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home's fire drill record indicates "Nearest Fire Exit" under the exit routes used for the fire drills conducted on 4/22/23, 5/15/23, 6/8/23, 7/27/23, 8/10/23 and 9/19/23.

Plan of Correction ***Accept ([redacted] - 06/28/2024)***

The homes fire drill record indicates "nearest fire exit" under the exit routes used for fire drills conducted on multiple dates.

The PC Administrator ensured the number of the exit door is currently indicated above each exit door on 05/17/2024. The PC Administrator will ensure exit routes are alternated on monthly fire drill records effective 05/17/2024.

PC Administrator educated maintenance to alternate exit routes on monthly fire drill records on 06/05/2024. Documentation of the education will be kept.
Audits will be completed monthly for 3 months beginning 06/05/2024 and ending 09/05/2024 Results of audits will be added to monthly QAPI meeting June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)

183d Current medications

13. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 5/9/24, there was a card for resident #1 containing 30 tablets of Guaifenesin ER 600mg – give one tablet by mouth every 12 hours as needed in the home's medication cart. However, the medication was discontinued on 3/19/24.

Plan of Correction ***Accept ([redacted] - 06/12/2024)***

Pc admin immediately removed the discontinued medication from the med cart. This was completed on 5/9/2024.

Pc admin or designee will conduct an audit of all med cart to ensure all discontinued medications are removed from the carts This will be completed by 6/5/2024. Documentation of the audits will be kept

An audit of the current med carts will be conducted by the Pc admin or designee to ensure there are no other discontinued medications still housed in the cart.

183d Current medications (continued)

Any found will immediately be removed. This audit will be completed by 6/5/2024. Documentation of the audit will be kept

Pc admin or designee will provide education to the Med Techs on the requirements of and the importance of the department's regulation 2800.183.d of removing removing medications from the med cart as soon as they are discontinued. This education will be completed by 6/5/2024. Documentation of the education will be kept.

Pc admin or designee will conduct daily audits, 5 days a week, for four weeks to ensure compliance with regulation 2800.13.d This audit will begin on 6/5/2024 and end on 7/3/2024.
Documentation of the audits will be reviewed and recorded in the monthly QAPI meeting

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 09/13/2024)

184a Resident meds labeled

14. Requirements

2800.
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

Resident #1 is prescribed Trulicity 3mg/0.5ml – Inject 3mg/0.5ml subcutaneously in the evening every Friday. However, the resident's medication label indicated Trulicity 3mg/0.5ml – Inject 3 mg/0.5ml subcutaneously in the evening every Thursday.

Plan of Correction ***Accept (- 06/12/2024)***

Resident 1's prescribed Trulicity was labeled properly on 5/9/2024. The facility will ensure that all resident medications are labeled properly.

Education will be provided by the PC Administrator and or designee to med- tech staff to ensure they properly understand the importance of medications being labeled correctly. Documentation of the education will be kept. Effective 6/5/2024 medication cart audits will be completed weekly for four weeks, starting 6/5/2024 and ending 7/3/2024.The results of audits will be reviewed and recorded in the monthly QAPI meeting

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 09/13/2024)

185a Storage procedures

15. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is prescribed Glucose Gel 40% - give 1 applicator by mouth as needed for hypoglycemia. However, this

185a Storage procedures (continued)

medication was not available in the home.

Resident #2 is prescribed Humalog KwikPen 100u/ml – inject subcutaneously 3 times a day per sliding scale – 141-180=1 unit, 181-220=2 units, 221-260=3 units, 261-300=4 units, 301-340=5 units, 341-999=6 units. However, the resident's May 2024 Medication Administration Record (MAR) indicates on 5/10/24 the resident had a blood glucose reading of 138 and did not receive insulin. However, the resident's glucometer indicates a blood glucose reading of 150 at 5:09 p.m. on 5/10/24.

Resident #2's May 2024 Medication Administration Record (MAR) indicates a blood glucose reading of 110v on 5/15/24 before supper and a blood glucose reding of 122 on 5/12/24 before lunch. However, these readings are not recorded on the resident's glucometer.

Plan of Correction ***Accept ([redacted] - 06/28/2024)***

Resident #1 is prescribed Glucose Gel 40% - give 1 applicator by mouth as needed for hypoglycemia. However, this medication was not available in the home. The PC Administrator ordered the Glucose Gel 40%, and it was available in the home on 5/10/2024.

The PC Administrator educated staff 5/10/2024 on glucometer use. Documentation of the education will be kept. The administrator and or designee will conduct weekly medication cart audits effective 6/5/2024 and ending 7/3/2024 to ensure proper storage procedures of medications.

Resident #2 is prescribed Humalog KwikPen 100u/ml – inject subcutaneously 3 times a day per sliding scale- 141-180=1 unit, 181-220=2units, 221-260=3units, 261-300=4units, 301-340=5units, 341-999=6units. However, the residents May 2024 Medication administration record MAR indicates 5/10/2024 the resident had a blood glucose of 138 and did not receive insulin. However the resident's glucometer indicates a blood glucose reading of 150 at 5:09 P.m. on 5/10/2024.

The PC Administrator educated staff on 5/10/2024 on glucometer use and recording. Documentation of the education will be kept.

Effective 6/5/2024 the PC Administrator and or designee will monitor 5 glucometer readings monthly on all diabetic residents using a glucometer. Glucometer readings will be compared to data on the MAR to ensure accuracy on glucometer use .The results of audits will be reviewed and recorded in the monthly QAPI meeting.

Resident #2 May 2024 Medication Administration Record (MAR) indicates a blood glucose reading of 110on 5/15/2024 before supper and a blood glucose reading of 122 on 5/12/2024 before lunch. However, these readings are not recorded on the residents' glucometer.

The PC Administrator educated staff on 5/10/2024 on glucometer use and recording. Documentation of the education will be kept.

185a Storage procedures (continued)

Effective 6/5/2024 the PC Administrator and or designee will monitor 5 glucometer readings monthly on all diabetic residents using a glucometer. Glucometer readings will be compared to data on the MAR to ensure accuracy on glucometer use .The results of audits will be reviewed and recorded in the monthly QAPI meeting June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 09/13/2024)

187b Date/time of med admin

16. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 was prescribed Novolin 70/30 FlexPen 100U/ml – Inject 6 units subcutaneously one time a day on 4/10/24. The resident's April Medication Administration Record (MAR) indicates the medication was administered on 4/11/24 through 4/16/24. However, according to resident and staff interviews, the resident's medication was found unopened on 4/16/24 and multiple staff had incorrectly administered the resident's Novolin R medication in place of the Novolin 70/30 medication.

Plan of Correction ***Accept (- 06/28/2024)***

Resident #1 is no longer prescribed Novolin 70/30 Flexpen 100u/ml the medication was removed from the med cart.

The PC Administrator educated Med- Techs on the requirements, importance and ensured understanding of regulation 2800.187.b on 06/05/2024. The PC Administrator educated Med-Techs on the five rights of medication on 04/16/2024 the documentation of this education will be kept.

The Pc Administrator or designee will conduct daily med cart audits for four weeks to ensure compliance with regulation 2800.187.b. beginning 6/5/2024 and ending on 7/3/2024. Routine weekly med cart audits will continue effective 07/10/2024

Documentation of the audits will be reviewed and recorded in the monthly QAPI meeting June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 09/13/2024)

187d Follow prescriber's orders

17. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

187d Follow prescriber's orders *(continued)*

Description of Violation

Resident #1 was prescribed Novolin 70/30 FlexPen 100U/ml – Inject 6 units subcutaneously one time a day on 4/10/24. The resident's April Medication Administration Record (MAR) indicates the medication was administered on 4/11/24 through 4/16/24. However, according to resident and staff interviews, the resident's medication was found unopened on 4/16/24 and multiple staff had incorrectly administered the resident's Novolin R medication in place of the Novolin 70/30 medication. Additionally, the resident was hospitalized on 4/14/24 due to hyperglycemia caused by the medication error

Resident #2 is prescribed Humalog KwikPen 100u/ml – inject subcutaneously 3 times a day per sliding scale – 141-180=1 unit, 181-220=2 units, 221-260=3 units, 261-300=4 units, 301-340=5 units, 341-999=6 units. However, the resident's May 2024 Medication Administration Record (MAR) indicates on 5/10/24 the resident had a blood glucose reading of 138 and did not receive insulin. However, the resident's glucometer indicates a blood glucose reading of 150 at 5:09 p.m. on 5/10/24.

Repeat Violation: 9/14/23

Plan of Correction ***Accept ([redacted] - 06/28/2024)***

The home shall follow the directions of the prescriber.

Resident #1 is no longer prescribed Novolin 70/30 Flexpen 100u/ml the medication was removed from the med cart.

The PC Administrator educated staff on the 5 rights of medication administration at time of medication error and on 5/17/2024. Documentation will be kept.

The Pc Administrator or designee will conduct daily med cart audits for four weeks to ensure compliance with regulation 2800.187.b. beginning 6/5/2024 and ending on 7/3/2024. Routine weekly med cart audits will continue effective 07/10/2024

Resident #2 prescribed insulin Humalog Kwikpen 100u/ml the facility will ensure resident #2's insulin Humalog 100u/ml will be administered correctly according to the prescribed sliding scale. Medication Administration Record (MAR) indicates a different blood glucose reading against what is recorded on the residents glucometer.

The PC Administrator educated staff on glucometer use 5/17/2024. Documentation of the education will be kept.

Effective 6/5/2024 the PC Administrator and or designee will monitor 5 glucometer readings monthly on all diabetic residents using a glucometer. Documentation will be kept. Glucometer readings will be compared to data on the MAR to ensure accuracy on glucometer use. The results of the audits will be reviewed and recorded in monthly QAPI meeting June 19, 2024.

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 09/13/2024)