

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

November 18, 2024

[REDACTED], ADMINISTRATOR  
OUR HOME OF HOPE INC  
223-225 CHERRY STREET  
COLUMBIA, PA, 17512

RE: OUR HOME OF HOPE  
223-225 CHERRY STREET  
COLUMBIA, PA, 17512  
LICENSE/COC#: 33322

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/12/2024, 06/13/2024 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:** OUR HOME OF HOPE **License #:** 33322 **License Expiration:** 06/13/2025  
**Address:** 223 225 CHERRY STREET, COLUMBIA, PA 17512  
**County:** LANCASTER **Region:** CENTRAL

**Administrator**

**Name:** [REDACTED]

**Legal Entity**

**Name:** OUR HOME OF HOPE INC  
**Address:** 223-225 CHERRY STREET, COLUMBIA, PA, 17512  
**Phone:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** C-2 LP **Date:** 04/14/1994 **Issued By:** Labor and Industry

**Staffing Hours**

**Resident Support Staff:** 0 **Total Daily Staff:** 27 **Waking Staff:** 20

**Inspection Information**

**Type:** Full **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Renewal, Complaint, Incident **Exit Conference Date:** 06/13/2024

**Inspection Dates and Department Representative**

06/12/2024 - On-Site: [REDACTED]  
06/13/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information			
License Capacity:	30	Residents Served:	27
Secured Dementia Care Unit			
In Home:	No	Area:	
Capacity:		Residents Served:	
Hospice			
Current Residents:	0		
Number of Residents Who:			
Receive Supplemental Security Income:	24	Are 60 Years of Age or Older:	21
Diagnosed with Mental Illness:	14	Diagnosed with Intellectual Disability:	6
Have Mobility Need:	0	Have Physical Disability:	3

**Inspections / Reviews**

06/12/2024 Full  
**Lead Inspector:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 07/12/2024

07/16/2024 - POC Submission  
**Submitted By:** [REDACTED] **Date Submitted:** 08/26/2024  
**Reviewer:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 07/23/2024

Inspections / Reviews *(continued)*

07/26/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/26/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/26/2024

11/18/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/26/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 06/12/2024, a copy of the 2600 regulations was not posted in a conspicuous and public place in the home.

Plan of Correction

Directed [redacted] - 07/26/2024)

-Administrator or Designee on 6/13/2024 will ensure to placed copy of 2600 Handbook at Desk area were residents make phone calls was completed on 6/13/2024.

-Administrator or Designee will ensure a copy of the 2600 handbook and copy of DHS Regulations Compliance Guide is posted on 6/13/2024 in a conspicuous and public place in the home where both staff and resident know that it is located by resident phone desk.

- Administrator or Designee will post a sign that a copy of both 2600 Handbook and Regulations is also available upon request and located in the office completed on 6/13/2024.

Administrator or designee will monitor to ensure on-going compliance with monthly walk throughs to ensure 2600 book, DHS Regulations Compliance Guide remains at resident desk area and sign remains posted completed by 7/31/2024.

Administrator will educate staff and residents on location and not moving items from resident desk area.

- Administrator or Designee will include review regulation and compliance to ensure a Copy of DHS Regulation Compliance Guide and 2600 Handbook in quarterly QA meetings next meeting scheduled 8/20/2024.

Proposed Overall Completion Date: 08/20/2024

[Directed]

- Administrator or designee will education staff and residents on location and not moving items from resident desk area by 8/26/24. Documentation of education will be kept and available for review by the Department.

- Beginning no later than 8/26/24, the Administrator or designee will complete monthly walk throughs to ensure Chapter 2600 regulations remain at resident desk area and sign remains posted. Documentation of these walk throughs will be kept and available for review by the Department.

Directed Completion Date: 08/26/2024

Implemented [redacted] - 11/18/2024)

16c - Written Incident Report

2. Requirements

2600.

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

Description of Violation

On [redacted], Staff Person A became aware of possible resident financial abuse. However, the home did not report this incident to the Department until [redacted].

16c Written Incident Report (continued)

Plan of Correction

Directed (████) - 07/26/2024

Administrator or Designee was complete by ██████ to ensure an incident report is filed within 24 hours regardless of available information and review all incident reports at daily stand up meeting to ensure compliance. Administrator or Designee will continue to collect information and provide DHS with updates as information becomes available.

Administrator or Designee will comply with regulations and compliance indicated in the DHS Regulatory Compliance Guide

Administrator or Designee will complete a quarterly audit on incident report based on initial reporting/ update reporting completed by 7/31/2024.

Administrator will include training in annual training calendar.

Administrator or Designee will include Audit form and Incident Report Form in quarterly QA meetings, next meeting scheduled 8/20/2024.

Proposed Overall Completion Date: 08/20/2024

[Directed]

Administrator or designee will educate all staff on reporting of reportable incidents and conditions by 8/26/24. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 08/26/2024

Implemented (████) - 11/18/2024

20b6 - Interest Bearing Account

3. Requirements

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

- 6. If a home is holding more than \$200 for a resident for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

Description of Violation

The home held money for Residents 1, 2, 3, 4, 5, and 6 for a minimum of 2 consecutive months, during which time the balance of those funds did not fall below \$200. However, the home has not offered assistance in establishing an interest bearing account in the residents' name at a local Federally insured financial institution.

Plan of Correction

Accept (████) - 07/26/2024

Administrator or Designee will develop a form for residents that complies with DHS Regulatory Compliance requirements, that offering assistance to residents in establishing interest bearing account with funds over 200.00 will be completed by 7/31/2024.

Administrator will educate resident(s) on interest bearing account form on 8/5/2024.

Administrator or Designee will establish a system to manage during disbursement of 85.00 each month with monthly Audit completed by 7/31/2024.

20b6 - Interest Bearing Account (continued)

-Administrator or Designee will include Interest Bearing Account Form and review same at quarterly QA meetings, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/05/2024

Implemented ( ) - 11/18/2024)

42b - Abuse

4. Requirements

2600.

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

Description of Violation

Staff Person B obtained banking information from Resident 7's personal checking account via a debit card. From [redacted] Staff Person B transferred at minimum [redacted] from the resident's personal checking account to the Staff Person B's personal PayPal account and made various unauthorized purchases. Staff Person B was terminated as a result.

Plan of Correction

Accept ( ) - 07/26/2024)

-Administrator or Designee will educate staff during Annual Staff Training on Resident Rights, and forms of Abuse completed by 8/30/2024.

-Administrator or Designee will educate residents at Resident Council Meeting about Resident Rights, and forms of Abuse completed by 8/30/2024.

-Administrator or Designee will be review annual staff training calendar included Staff Training in quarterly QA meetings to ensure compliance at next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/30/2024

Implemented ( ) - 11/18/2024)

51 - Criminal Background Check

5. Requirements

2600.

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

Description of Violation

Staff Person A began working in the home on [redacted]. However, a criminal background check was not requested until [redacted].

Staff Person C began working in the home on [redacted]. However, a criminal background check was not requested until [redacted].

Plan of Correction

Accept ( ) - 07/26/2024)

-Administrator will start on 7/12/2024 criminal background check prior to staff members first day on facility floor.

- Administrator will complete initial audit of all current employee(s) records to ensure compliance completed by 7/31/2024.

-Administrator will continue to use Staff Audit tool for New Employee's and will add criminal background checks completed 7/31/2024.

51 - Criminal Background Check (continued)

- Administrator will education Clinical LPN Nurse Supervisor to ensure criminal background checks are completed on or before start date on the floor by 7/12/2024.
- Administrator will review Staff Audit Tool quarterly starting 7/31/2024.
- Administrator will include Criminal Background Check Audit in quarterly QA meeting, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/20/2024

Implemented [redacted] - 11/18/2024)

63a - First Aid/CPR Training

6. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 06/06/2024, 06/07/2024, and 06/08/2024, from 2:00PM-06:00AM, 27 residents were present in the home. During this time, there were no staff persons present in the home who were certified in First Aid.

Plan of Correction

Directed [redacted] - 07/26/2024)

- Administrator or Designee on 6/13/2024 contacted American Red Cross instructor to secure CPR documentation and will be obtain by 8/31/2024.
- Administrator or Designee will start on 6/13/2024 to use Staff Audit Tool and check tool monthly to ensure to comply with DHS Regulations Compliance Guide.
- Administrator will review Staff Audit Tool and Staff Schedule monthly to ensure compliance.
- Administrator will educate staff at next Staff meeting scheduled 9/19/2024.
- Administrator will include Staff Audit Tool in quarterly QA meeting, next meeting scheduled 8/20/2024.

Proposed Overall Completion Date: 09/19/2024

[Directed]

- Administrator or designee will educate all staff on this regulation by 8/26/24. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 09/19/2024

Implemented [redacted] - 11/18/2024)

65f - Training Topics

7. Requirements

2600.

65.f. 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. Personal care service needs of the resident.

65f - Training Topics (continued)

**Description of Violation**

Direct care Staff Person D did not receive training in the following topics during the 2023 training year:

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

**Plan of Correction**

Accept ( ) - 07/26/2024)

- Administrator or Designee will include training topics on 7/31/2024 such as Medications Self-Training, Instruction on meeting the needs of the Residents as described in the readmission screening form, assessment tool, medical evaluation and support plans to stay compliant with DHS Regulatory Compliance Guide completed by 12/31/2024.
- Administrator or Designee will be included as additional training several months in advance in Annual Staff Training calendar based on job description (All-Staff Training or Med Tech only Training).
- Administrator will start quarterly on 7/31/2024 staff training audit to ensure all staff are up to date on their trainings and continues on going compliance.
- Administrator will schedule staff trainings and educate staff by next Staff Meeting on 9/19/2024. Annual Staff Training(s) will be completed by 12/31/2024.
- Administrator or Designee will discuss additional training topics to be included in Annual Staff Training Calendar the prior year for the next year in quarterly QA meetings, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ( ) - 11/18/2024)

85b - Infestation

**8. Requirements**

- 2600.
- 85.b. There may be no evidence of infestation of insects or rodents in the home.

**Description of Violation**

On ( ), live bedbugs were observed in resident rooms 206 and 208.

**Plan of Correction**

Directed ( ) - 07/26/2024)

- Administrator or Designee scheduled and treated rooms 206, 208 was completed on 7/9/2024.
- Universal Worker will educate on Bed Bug Education at next staff meeting scheduled 9/19/2024.
- Administrator educated resident(s) at resident meeting on Bed Bug Education scheduled on 7/23/2024.
- Universal Worker on 7/22/2024 started weekly walk throughs resident room checks.
- Administrator or Designee will continue to work with Pest Control Company for guidance to resolve issue.
- Administrator or Designee will include and review all documentation in quarterly QA meetings, next meeting scheduled 8/20/2024.

Proposed Overall Completion Date: 09/19/2024

[Directed]

- Administrator or designee will educate all staff on the signs of bed bugs and what they should do if signs of infestation are observed by 8/26/24. Documentation of this education will be kept and available for review by the Department.

85b - Infestation (continued)

Directed Completion Date: 09/19/2024

Implemented ( ) - 11/18/2024)

107d - Procedure Emergency Management Agency Submission

9. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed/updated and submitted to the local emergency management agency since October of 2022.

Plan of Correction

Directed ( ) - 07/26/2024)

- Administrator or Designee will forward Our Home of Hope's Emergency Management Procedure to local Emergency Management Agency to maintain compliance with DHS Regulations Compliance Guide completed by 7/31/2024.
- Administrator will be responsible for scheduling annual reviews and updating written emergency procedure as of 6/13/2024.
- Administrator or Designee will include Emergency Management Procedure to the Annual Staff Training Calendar on 6/13/2024.
- Administrator or Designee will include Emergency Management Procedure to review in quarterly QA meetings, next meeting scheduled 8/20/2024.

Proposed Overall Completion Date: 08/20/2024

[Directed]

- Administrator was educated on this regulation by Inspectors on 6/13/24.

Directed Completion Date: 08/20/2024

Implemented ( ) - 11/18/2024)

132c - Fire Drill Records

10. 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 04/30/2024 the home had a fire drill conducted by a fire safety expert. The fire safety expert documented the alarm was signaled at 6:10PM, took a total of 2 minutes and 53 seconds to evacuate the building, and states 28 residents were in the building during the drill. However, the home's fire drill log states the fire drill was conducted at 6:00PM, took a total of 2 minutes and 33 seconds to evacuate the building, and states 29 residents were in the building during the drill. Furthermore, the home's fire drill doesn't include documentation of how many staff participated in the fire drill.

132c Fire Drill Records (continued)

The home's fire drill logs from 06/30/2023 05/30/2024 document that "ALL" exits are used. Upon interviewing staff, fires are simulated in specific locations and simulate blocked exits. However, the home does not document this.

The fire drill log/record for the drill conducted in December 2023 does not include the specific date on which the fire drill took place.

Plan of Correction

Directed [redacted] - 07/26/2024)

Administrator or Designee have reviewed Fire Drill logs on 6/30/2024.

Universal Worker to ensure proper documentation and is in compliance with DHS Regulatory Compliance Guide completed by 7/31/2024.

Administrator or Designee will conduct Monthly Fire Drill Log Audits to stay compliant with DHS Regulatory Compliance Guide started 6/13/2024.

Administrator or Designee will ensure all information is included in Monthly Fire Drill Log Audits well documented, no missing information and reviewed to ensure compliance completed monthly starting 6/13/2024.

Administrator or Designee will include Monthly Fire Drill Log Audits in quarterly QA meetings to ensure compliance, next meeting scheduled 8/20/2024.

Proposed Overall Completion Date: 08/20/2024

[Directed]

Administrator or designee will educate Universal Worker on regulation by 8/26/24. Documentation of education will be kept and available for review by the Department.

Directed Completion Date: 08/26/2024

Implemented [redacted] - 11/18/2024)

132d - Evacuation

11. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

Prior to 05/23/2023, the home did not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drill: On 05/19/2023 at 5:36AM, the evacuation time was 3 minutes and 8 seconds.

Repeated Violation 05/02/2023

Plan of Correction

Accept [redacted] - 07/26/2024)

Administrator or Designee has reviewed Fire drill logs on 6/13/2024 and found that the home exceeded evacuation time.

Administrator or Designee addressed the allotted time with the Fire Chief on 6/2/2022, 5/23/2023, and on 4/30/2024. See attached

132d Evacuation (continued)

Administrator or Designee staff member will be educated on DHS Regulatory Compliance on Fire Drill Safety Requirements will be completed on 7/30/2024.

Administrator or Designee will review Fire Drill Logs to be include with documentation from Columbia Fire Chief in quarterly QA meetings to ensure compliance, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/20/2024

Implemented ( ) - 11/18/2024)

132h - Designated Meeting Place

12. Requirements

2600.

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

Description of Violation

During the fire drill on 01/31/2024 at 10:30AM, one resident refused to participate and did not evacuate to a designated meeting place away from the building or within the fire safe area.

Plan of Correction

Accept ( ) - 07/26/2024)

Administrator or Designee spoke with resident # 8 about the importance of evacuating the building and reporting to designated meeting place completed on 7/31/2024.

Administrator or Designee will discuss at next resident meeting scheduled 7/23/2024 on Fire Safety, Evacuation, and Reporting to designated area to be accounted for in census during an emergency situation and will be included in Resident Council Minutes completed 7/23/2024.

Universal Worker will review fire drill logs monthly to make sure everyone participates in the evacuation will start on 7/31/2024.

Administrator or Designee will included on discussion Fire Safety Training in Annual Staff Training Calendar in quarterly QA meetings, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/20/2024

Implemented ( ) - 11/18/2024)

162c - Menus Posted

13. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 06/12/2024, the menus for the current week (06/09/2024 06/15/2024) and the following week (06/16/2024 06/22/2024) were not posted.

Plan of Correction

Accept ( ) - 07/26/2024)

Administrator or Designee on 6/13/2024 educated new Cook on Dietary Menu's and when they need to be for residents to view at designated spot.

Administrator or Designee will ensure the Cook posts the current and

162c - Menus Posted (continued)

upcoming menu for residents to view at designated spot.

- Cook will complete weekly checks to ensure on going compliance starting 7/29/2024.

-Administrator or Designee will include discussion of Menu's in quarterly QA meetings, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/20/2024

Implemented [redacted] - 11/18/2024)

183e - Storing Medications

14. 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

On [redacted], a loose white, round pill stamped with "44/104" was located in a medication drawer of the med cart.

Plan of Correction

Accept [redacted] - 07/26/2024)

-Administrator or Designee removed and disposed of loose med upon finding med in Med Cart completed on 6/13/2024.

-Administrator or Designee will train all Med Tech's and LPN on proper medication administration and compliance. This training will be completed by 8/30/2024 and submitted to DHS for approval upon completion.

-Administrator or Designee will start on 6/13/2024 to conduct monthly Med Cart audits to ensure prescriptions are current, MARs are compliant, and maintain medications under proper conditions.

-Administrator or Designee will include training based on job description in Annual Staff Training Calendar and Med Cart Audits in quarterly QA meetings, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/30/2024

Implemented [redacted] - 11/18/2024)

185a - Implement Storage Procedures

15. 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

Resident 8 is prescribed PRN [redacted] However, on [redacted], this medication was not available in the home.

Resident 9 is prescribed PRN [redacted] tablet. However, on [redacted], this medication was not available in the home.

On [redacted], Resident 9 had the following discrepancies between the blood sugar readings on the Medication Administration Record (MAR) and the glucometer:

185a Implement Storage Procedures (continued)

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED].

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

On [REDACTED], the glucometer had a reading of [REDACTED]. However, the resident's blood sugar was documented as [REDACTED] in the MAR.

Repeated Violation 05/02/2023

Plan of Correction

Accept ( [REDACTED] ) - 07/26/2024)

Clinical Nurse Supervisor on 6/13/2024 contacted PCP for clarification on PRN medications, medications were discontinued on 6/13/2024.

Administrator or Designee will train all Med Tech's and LPN staff to ensure proper medication administration and compliance completed by 8/30/2024 to maintain medication compliance based on DHS Regulatory Compliance Guide and documentation accuracy from Staff.

Clinical Nurse Supervisor will complete on going Monthly Med Cart Audits to ensure all current prescribed medications are available on site started on 7/31/2024.

Administrator or Designee will Audit MAR's monthly starting 7/1/2024.

Administrator or Designee will be included monthly MAR's along with staff training material in quarterly QA meetings to ensure compliance, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/20/2024

Implemented ( [REDACTED] ) - 11/18/2024)

187d - Follow Prescriber's Orders

16. Requirements

2600.

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

Description of Violation

Resident 9 is prescribed Lantus Solostar INS 100U/M with orders to inject [REDACTED] subcutaneously 2 times a day HLD (hold) for blood sugar less than [REDACTED]

187d - Follow Prescriber's Orders (continued)

On [redacted] at [redacted] the resident had a blood sugar reading of [redacted] and was administered [redacted] units.  
On [redacted] at [redacted], the resident had a blood sugar reading of [redacted] and was administered [redacted] units.  
On [redacted] at [redacted], the resident had a blood sugar reading of [redacted] and was administered [redacted] units.

Resident 9 is prescribed [redacted] tablets, with orders to take 1 tablet by mouth daily. However, on [redacted], the [redacted] located in the cart and being administered to the resident is a dosage of [redacted] mcg per tablet.

Plan of Correction

Accept [redacted] - 07/26/2024)

- Administrator or Designee on 6/13/2024 contacted PCP and requested clarification for [redacted] on Resident #9 from PCP completed on [redacted]
- Administrator or Designee will educate and train Med Tech's and LPN on proper medication administration and compliance with emphasis on Diabetic Residents to include insulin and Sliding Scale training completed by 8/30/2024.
- Administrator or Designee when completing Monthly Med Cart Audit to include checking to ensure Diabetic Residents insulin and medication dosages are compliant with provider's orders and documented with accuracy and will start 7/31/2024.
- Administrator or Designee will be included Med Tech Training material, and Med Cart Audit in quarterly QA meetings to ensure compliance, next meeting scheduled 8/20/2024.

Licensee's Proposed Overall Completion Date: 08/30/2024

Implemented [redacted] - 11/18/2024)

190a - Completion Medication Course

17. 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

Staff Person A who serves as the Train-the-Trainer for the home, passes medications, and functions as the practicum observer has not completed the standard Department-approved medication administration training. Staff Person A administered medications to Resident 9 on the following dates and times:

[redacted]

Plan of Correction

Directed [redacted] - 07/25/2024)

- Administrator has complete DHS approved medication administration course on [redacted] that includes practicum observer training.
- Administrator or Clinical LPN Nurse Supervisor will complete initial audit of all current Med Tech Certifications should be completed to ensure all med Techs have completed the standard medication administration course completed by 7/31/2024.
- Administrator or Designee will maintain compliance with DHS Regulatory Compliance Guide

**190a - Completion Medication Course (continued)**

- Administrator will ensure all Med Tech's receive the required training at next Med Tech meeting and will be completed by 9/19/2024.
- Administrator on 7/31/2024 will complete quarterly Med Tech Audit to ensure on going compliance.
- Administrator or Designee will be included practicum observer training date in quarterly QA meetings, next meeting scheduled 8/20/2024.

*Proposed Overall Completion Date: 09/19/2024*

*[Directed]*

- Staff Person A will complete the Standard Medication Administration Course by 8/26/24. A copy of this certification will be kept and available for review by the Department.
- Any staff identified from the initial audit as not having a current Standard Medication Administration Certification will take the standard Medication Administration Course no later than 8/26/24. Copies of these certifications will be kept and available for review by the Department.
- Administrator was educated on this regulation by Inspectors on 6/13/24.

**Directed Completion Date: 09/19/2024**

**Implemented [REDACTED] - 11/18/2024)**