pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **STERLING HOUSE LLC**
LEGAL ENTITY

To operate **STERLING HOUSE**
NAME OF FACILITY OR AGENCY

Located at **432 EAST TULPEHOCKEN STREET, PHILADELPHIA, PA 19144**
(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 **10**
(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 **March 19, 2025** until **March 19, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142920**

ISSUING OFFICER

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing date: March 19, 2025

[redacted]
[redacted]
Sterling House
432 East Tulpehocken Street
Philadelphia, Pennsylvania 19144

RE: Sterling House
License #: 142920

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on January 13,2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

March 18, 2025

[redacted]
STERLING HOUSE LLC
[redacted]

RE: STERLING HOUSE
432 EAST TULPEHOCKEN STREET
PHILADELPHIA, PA, 19144
LICENSE/COC#: 14292

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/13/2025 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: *STERLING HOUSE* **License #**: *14292* **License Expiration**: *03/09/2025*

Address: *432 EAST TULPEHOCKEN STREET, PHILADELPHIA, PA 19144*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *STERLING HOUSE LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *R-3* **Date**: *12/16/2016* **Issued By**: *PA DEPT OF L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *6* **Waking Staff**: *5*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *01/13/2025*

Inspection Dates and Department Representative

01/13/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *10* **Residents Served**: *6*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *4*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

01/13/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/13/2025*

03/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/18/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/14/2025*

Inspections / Reviews *(continued)*

03/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/18/2025*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

03/18/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *03/18/2025*

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

42b - Abuse

1. Requirements

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

Description of Violation

On 01/13/25, between 10:15am and 10:30am, there were 5 residents present in the home and only 1 staff member on duty. During the on-site inspection, Staff member A informed the Agent of the Department that they were going to step out onto the front porch for a few moments. At approximately 10:20am, a residents case manager arrived onsite to meet with resident #2. The [redacted] reported that they waited in the home for approximately 10 minutes while residents looked for staff member A. Staff member A could not be located within the home or on the front porch as indicated, to assist resident #2's Case Manager. Staff Member A was located at approximately 10:30am, when they reported that they had to go next door to help a neighbor who required assistance.
Staff member A left the home unattended without any direct care staff or designee, to attend to a non-resident 10 to 15 minutes.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

On 01/13/25, Staff Member A made an independent decision to leave the home unattended for approximately 15 minutes to assist an elderly non-resident neighbor. While this action was taken with good intent, it resulted in the home being left without direct care staff, which is a violation of resident supervision requirements.

Corrective Actions Taken:

Staff Member A has acknowledged the lapse in judgment and understands the critical importance of maintaining supervision at all times while on duty.
A staff meeting was conducted on 01/27/25, during which all staff were trained on the new Resident Supervision & Duty Policy in alignment with 2600 42b to prevent similar incidents in the future.

Preventive Measures:

Effective immediately, staff are prohibited from leaving the home unattended for any reason while on duty. If an emergency arises, staff must contact the Administrator or designated supervisor before stepping away.
A Resident Supervision & Duty Policy has been reviewed and reinforced with all employees to ensure full understanding of responsibilities.
Unannounced compliance checks will be conducted by the Administrator to verify adherence to this policy. Any future violation of this policy will result in corrective action, including disciplinary measures as necessary.

Person Responsible for Compliance:

Administrator will ensure all staff comply with supervision policies and conduct regular training refreshers.
Completion Date:
1/27/25

Licensee's Proposed Overall Completion Date: *02/19/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

42s - Privacy

2. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 01/13/25 at 3:45pm, There is a camera on the third floor in the hallway that has a direct view of the residents bathroom. This camera is not directed towards an entrance of exit of the home and additionally there are no signs posted indicating that images are being monitored or recorded.

Plan of Correction ***Do Not Accept [redacted] - 03/12/2025)***

Corrective Actions Taken:

The camera has been immediately repositioned to face only the public staircase, eliminating any view of the bathroom area.
All staff have been informed of resident privacy rights to prevent similar issues in the future.
A review of all security cameras throughout the facility has been conducted to ensure no other cameras compromise resident privacy.

Preventive Measures:

Signage has been posted in the monitored area to clearly indicate that security cameras are in use.
The Administrator will conduct quarterly audits of camera placements to ensure continued compliance.

Completion Date:
1/14/25

Licensee's Proposed Overall Completion Date: *02/19/2025*

Update: *03/12/2025*

Please indicate the specific date of staff in-service training.
Please indicate if and when signage was posted regarding video surveillance/recording on site.

Plan of Correction ***Accept [redacted] - 03/18/2025)***

Corrective Actions Taken:
Please see attachment.

The camera has been immediately repositioned to face only the public staircase, eliminating any view of the bathroom area.

*During our staff meeting **1/27/25** we conducted a in-service training on residents privacy rights and open discussion to prevent similar issues in the future.*
A review of all security cameras throughout the facility has been conducted to ensure no other cameras compromise resident privacy.

Preventive Measures:

*On **1/14/25** signage has been posted in the monitored area to clearly indicate that security cameras are in use.*
The Administrator will conduct quarterly audits of camera placements to ensure continued compliance.

Completion Date:

42s - Privacy (continued)

1/14/25

Licensee's Proposed Overall Completion Date: 03/13/2025

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

57a - Designee Present/Age

3. Requirements

2600.
57.a. At all times one or more residents are present in the home a direct care staff person who is 21 years of age or older and who serves as the designee, shall be present in the home. The direct care staff person may be the administrator if the administrator provides direct care services.

Description of Violation

On 01/13/25, from 10:15am to approximately 10:30am, at least 5 residents were present in the home. During this time, there was no staff person present in the home.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

On 0[redacted]/25, Staff Member A made an independent decision to leave the home unattended for approximately 15 minutes to assist an elderly non-resident neighbor. While this action was taken with good intent, it resulted in the home being left without direct care staff, which is a violation of resident supervision requirements.

Corrective Actions Taken:
Staff Member A has acknowledged the lapse in judgment and understands the critical importance of maintaining supervision at all times while on duty.
A staff meeting was conducted on 01/27/25, during which all staff were trained on the new Resident Supervision & Duty Policy in alignment with 2600 42b to prevent similar incidents in the future.

Preventive Measures:
Effective immediately, staff are prohibited from leaving the home unattended for any reason while on duty. If an emergency arises, staff must contact the Administrator or designated supervisor before stepping away.
A Resident Supervision & Duty Policy has been reviewed and reinforced with all employees to ensure full understanding of responsibilities.
Unannounced compliance checks will be conducted by the Administrator to verify adherence to this policy. Any future violation of this policy will result in corrective action, including disciplinary measures as necessary.

Person Responsible for Compliance:
Administrator will ensure all staff comply with supervision policies and conduct regular training refreshers.
Completion Date:
1/27/25

Licensee's Proposed Overall Completion Date: 02/19/2025

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

63a - First Aid/CPR Training

4. Requirements

2600.

63a - First Aid/CPR Training *(continued)*

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

6 residents currently reside in the home. The home has three regular staff persons who work on rotating weekly shifts. All three staff do not have a valid certification for First Aid, CPR and obstructed airway techniques. The staff have a certificate from an online only course for CPR that does not include an in-person, practical skills test. This type of online only course is not acceptable. Staff member C had a valid certification that expired as of 7/22/2023.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

Corrective Actions Taken:

The Administrator and all staff members completed an in-person CPR, First Aid, and AED training course on 01/18/25, which included the required practical skills test. See attachment. Documentation of the newly obtained certifications has been placed in each staff member's personnel file for verification.

Preventive Measures:
Moving forward, all staff will be required to obtain First Aid, CPR, and obstructed airway certifications through an accredited in-person training provider.

Person Responsible for Compliance:
Administrator will ensure all staff maintain current, valid certifications and complete training as required.

Completion Date:
01/18/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *02/19/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

64c - Annual Training

5. 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

Staff person B, the [redacted], completed only 18 hours of Department-approved training in training year 2024.

Repeat Violation date: 2/29/24.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

Corrective Actions Taken:

The [redacted] successfully completed the remaining 6 hours of required training as follows:
3 hours of in-person CPR training on 01/18/25 .
3 hours of Fire Safety Train-the-Trainer training on 02/12/25. Certificates of completion for these courses have

64c - Annual Training (continued)

been documented in the [redacted] training file for verification.

Preventive Measures:
Better use of the staff training plan to ensure the [redacted] meets the required 24 hours annually.
The [redacted] will continue complete training throughout the year rather than near the end of the training period to prevent future deficiencies.
The [redacted]r will conduct biannual reviews of training progress to ensure compliance before the annual deadline.

Completion Date:
02/12/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

65g - Annual Training Content

6. Requirements

2600.
65.g. 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.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons A and C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2024.

Plan of Correction ***Accept[redacted] 03/12/2025)***

Corrective Actions Taken:

The Administrator completed the Train-the-Trainer Fire Safety Course on 02/12/25, ensuring proper qualifications to conduct training sessions.
All required staff, including Staff Persons A and C, successfully completed fire safety training on 02/17/25 under the guidance of a qualified instructor. The staff training plan has been updated with the new training date.

Preventive Measures:

The Administrator will conduct quarterly audits to verify and or schedule so staff received the necessary training.

65g - Annual Training Content (continued)

Completion Date:
02/17/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

93a - Handrails

7. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 1/13/25, the landing for the fire escape on top of the garage has a handrail that is loose and poorly secured.
The second-floor balcony porch on the side of the home has handrail that is is broken at the top rail where it connects to the post, making the railing loose and unsafe.

Plan of Correction ***Accept[redacted] 03/12/2025)***

Corrective Actions Taken:
On 01/24/25, a licensed general contractor was hired to repair and reinforce all handrails, ensuring they are properly secured and meet safety standards.
A post-repair inspection was conducted by the Administrator to verify the quality and security of the repairs.

Preventive Measures:
Staff will be trained to report any signs of wear, damage, or instability in railings immediately.The Administrator will conduct random safety checks to ensure compliance with safety regulations.

Completion Date:
01/24/25 (Completed) and Ongoing Compliance Monitoring.

Note: I attempted to upload pictures of the now secured railing but the upload continued to failed. They can be emailed if requested.

Licensee's Proposed Overall Completion Date: *02/19/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

95 - Furniture and Equipment

8. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 01/13/25 at 2:30 pm, the home's dryer was connected to an extension cord that was plugged in to an outlet outside the laundry room. The home's dryer is located on the 2nd floor and near resident #1's room. Per the dryer's manufacturer's instructions, the dryer cannot be connected to an extension cord as it draws too much power and can easily overload a standard extension cord, potentially causing a fire hazard.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Accept [redacted] - 03/12/2025)***

Corrective Actions Taken:
On 01/14/25, an electrician was hired to restore the dedicated outlet in the laundry room that meets the electrical requirements of the dryer.
The dryer is now plugged directly into a wall outlet, eliminating the fire risk.
A post-installation inspection was conducted to ensure proper wiring and compliance with safety standards.

Preventive Measures:
Staff have been trained to report any improper use of extension cords or electrical hazards immediately.
The Administrator will conduct quarterly safety inspections of all major appliances to ensure proper electrical connections.

Completion Date:
01/14/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *02/19/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

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 submitted to the local emergency management agency since 08/10/20.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

See attached.

Corrective Actions Taken:
The home's emergency plan was reviewed, updated to reflect current procedures and best practices.
On 01/14/25, the updated emergency plan was submitted to the City of Philadelphia Office of Emergency Management for compliance.
Confirmation of receipt from the emergency management agency has been documented and filed.

Preventive Measures:
A tracking system has been implemented to ensure the emergency plan is reviewed, updated, and submitted annually.

Person Responsible for Compliance:
Administrator will oversee the annual review and submission process.

Completion Date:
01/14/25 (Completed) and Ongoing Compliance Monitoring.

107d - Procedure Emergency Management Agency Submission *(continued)*

Licensee's Proposed Overall Completion Date: *02/19/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

126a - Furnace Inspection

10. Requirements

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home does not have documentation of the last furnace inspections.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

See attached.

Corrective Actions Taken:

On 01/24/25, a furnace inspection was completed by [redacted], and documentation of the inspection has been filed and maintained for compliance.
The furnace was found to be in proper working condition, and any necessary maintenance has been addressed.

Preventive Measures:
A tracking system has been implemented to ensure annual furnace inspections are scheduled and documented.

Person Responsible for Compliance:
Administrator will oversee the scheduling, completion, and documentation of annual furnace inspections.

Completion Date:
01/24/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *02/19/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

Resident #2's most recent medical evaluation was completed on [redacted]/23.

Repeat violation date: 2/29/24.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

Corrective Actions Taken:
The resident was originally scheduled for their annual medical evaluation by 12/09/24 to ensure compliance.

141b1 - Annual Medical Evaluation (continued)

However, due to unexpected staff changes, including the sudden resignation of the resident's long-standing [redacted], the appointment was missed.
A new [redacted] was assigned, but changes again in case management caused further scheduling delays.
The resident's annual medical evaluation was successfully rescheduled and completed on 02/27/25. Documentation of the completed DME is attached for verification.

Preventive Measures:
The home actively tracks medical evaluation due dates using a documented tracking system to ensure compliance.
To prevent future disruptions, staff will verify upcoming appointments 1 week in advance directly with the resident's case manager.
Person Responsible for Compliance:
Administrator will oversee tracking and follow-up on all resident medical evaluations.
Completion Date:
02/27/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Bypass Document Submission ***Implemented ([redacted] - 03/18/2025)***

185a - Implement Storage Procedures

12. 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 #1 has a glucometer and lancets with directions to check glucose twice a day. The home does not have a record of any glucometer checks or glucose log.

Plan of Correction ***Accept [redacted]S - 03/12/2025)***

Corrective Actions Taken:
The prescribed usage and testing frequency from the resident's physician has been added to the Medication Administration Record (MAR) to ensure compliance with the prescribed regimen.

A glucose monitoring log has been created and will be maintained for Resident #1 and any future residents requiring glucose monitoring will receive a seperate log.

Preventive Measures:
A monthly audit of Log will be conducted by the Administrator to verify that all prescribed medical equipment use is properly documented.

Person Responsible for Compliance:
Administrator will oversee compliance monitoring, and record-keeping for all medical equipment usage.

Completion Date:
Updated MAR on 01/20/25 (Completed) and Ongoing Compliance Monitoring.

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *02/20/2025*

Bypass Document Submission ***Implemented [redacted] 03/18/2025)***

13. 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

On 1/13/25, Resident #1's glucometer was not calibrated to the correct time. The glucometer showed a time of 7:03am when actual time was 2:35pm.

Plan of Correction ***Accept[redacted] - 03/12/2025)***

Corrective Actions Taken:
The glucometer was updated to reflect the correct time immediately upon discovery. Staff have been trained on proper calibration procedures for glucometers and other medical devices to ensure accurate readings and record-keeping.

Preventive Measures:
A monthly check of all medical equipment requiring time-sensitive accuracy glucometers has been implemented to ensure proper calibration.
A designated staff person will verify and update glucometer settings as part of routine medical equipment maintenance.
The Administrator will conduct random spot checks to ensure compliance with calibration.
Person Responsible for Compliance:
Administrator will oversee routine maintenance and ensure staff adherence to calibration procedures.

Completion Date:
01/13/25 (Completed) and Ongoing Compliance

Proposed Overall Completion Date: 02/20/2025

Licensee's Proposed Overall Completion Date: *02/20/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

187a - Medication Record

14. 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.

187a - Medication Record *(continued)*

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 #1 is prescribed glucose check twice daily, however, it is not included on resident #1's medication administration record.

Repeat Violation 05/20/24.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

See attached.

Corrective Actions Taken:
On 01/20/25, the resident's physician provided a written prescription for glucose monitoring, specifying:
"ACCU-CHECK Glucometer
Check blood sugar once every other day"
On 01/21/25, the prescription was added to the MAR, ensuring proper documentation and compliance with physician orders.

Preventive Measures:
The Administrator will conduct monthly MAR audits to verify that all prescribed medications and medical equipment usage are accurately documented.

Completion Date:
01/21/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *02/20/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident #1 is prescribed glucose checks twice a day. However, resident#1's glucometer does not have readings indicating two checks daily. glucose check was not completed as prescribed. The only readings in the glucometer are for the following dates: 1/2/25 at 3:01am,1/6/25 at 2:37am, 1/7/25 at 1:29am, 1/8/25 at 1:28am, 1/10/25 at 12:45am, 1/12/25 at 1:09am.

Repeat Violation 05/20/24, 2/29/24 .

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept [redacted] - 03/12/2025)***

See attached.

Corrective Actions Taken:
On 01/15/25, the resident's physician reviewed and updated the prescription to reflect a revised monitoring schedule: Use glucometer to check blood sugar once every other day instead of twice daily.
The Medication Administration Record (MAR) was immediately updated to reflect the revised prescription.

Preventive Measures:
The Administrator conducted audits of medical equipment and MARs to ensure all prescribed monitoring is accurately recorded.

Completion Date:
01/15/25 (Completed) and Ongoing Compliance Monitoring.

Licensee's Proposed Overall Completion Date: *02/24/2025*

Bypass Document Submission ***Implemented [redacted] - 03/18/2025)***