pennsylvania
DEPARTMENT OF HUMAN SERVICES

Certificate of Compliance

This certificate is hereby granted to **450 EAST PHILADELPHIA AVENUE OPERATIONS LLC**
LEGAL ENTITY

To operate **MIFFLIN COURT**
NAME OF FACILITY OR AGENCY

Located at **450 EAST PHILADELHIA AVENUE, SHILLINGTON, PA 19607**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **67** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 14**

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

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

and shall remain in effect from **May 14, 2025** until **November 14, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **222062**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Pennsylvania
Department of Human Services

Sent via Email to: [redacted]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 14, 2025

Executive Director
450 East Philadelphia Avenue Operations LLC
450 East Philadelphia Avenue
Shillington Pennsylvania 19607

RE: Mifflin Court
License # 222062

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on December 3, 2024, February 7, 2025 and April 10, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from May 14, 2025 to November 14, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with Choose an item., must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

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

, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *MIFFLIN COURT* **License #**: *22206* **License Expiration**: *02/20/2025*

Address: *450 EAST PHILADELHIA AVENUE, SHILLINGTON, PA 19607*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *450 EAST PHILADELPHIA AVENUE OPERATIONS LLC*

Address: *450 EAST PHILADELPHIA AVENUE, SHILLINGTON, PA, 19607*

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *58* **Waking Staff**: *44*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date**: *04/15/2025*

Inspection Dates and Department Representative

04/10/2025 - On-Site: [redacted]

04/15/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *46*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *N/A* **Capacity**: *14* **Residents Served**: *11*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*

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

Have Mobility Need: *12* **Have Physical Disability**: *0*

Inspections / Reviews

04/10/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/26/2025*

Inspections / Reviews *(continued)*

04/29/2025 - POC Submission

Submitted By: [redacted]

Date Submitted: *04/26/2025*

Reviewer: [redacted]

Follow-Up Type: *Enforcement*

16c - Written Incident Report

1. 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

Resident #1 has an order for Eliquis 5 mg tablet take 1/2 tablet by mouth twice daily. The medication was not administered on 4/8/25 at 9:00 p.m. and 4/9/25 at 9:00 a.m. The medication error was not reported to the Department.

Plan of Correction ***Directed (- 04/28/2025)***

Executive Director immediately reported the medication error found by BHS on 4/10/2025 on 4/10/2025. An in-service was given by the Executive Director on 4/11/2025 in regards to unavailable medications corresponding with the resident missing the medication and to report it to the Executive Director or Director of Health and Wellness. This is to ensure that a State incident reportable has been completed in a timely manner. Executive Director and Director of Health and Wellness are responsible for maintaining compliance by reviewing notes in PCC daily, continuing education with staff, verbally checking with staff on any missing medications, and continued med cart audits. Eliquis was received the evening of 4/10/2025.

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: All staff will be trained in reportable incidents and conditions. The training will also include the homes internal policy on reporting and who is responsible for reporting on holidays and weekends.

Directed Completion Date: *05/31/2025*

181c - Self-administration Assessment

2. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2 is self administering Butenafine cream but has not been assessed by a physician to be able to do so. The residents medical evaluation dated 9/10/24 notes the resident is unable to self administer medications.

Plan of Correction ***Directed (- 04/28/2025)***

Butenafine cream for resident #2 was removed immediately on 4/10/2025 by the nurse on duty. Order sent to PCP for resident #2 to be able to self administer the butenafine cream on 4/10/2025. Received signed order back from PCP stating resident #2 may keep the cream at bed side and self administer. In-service completed with staff by Executive Director on 4/11/2025 educating them about finding prescribed medicines in the rooms. Executive Director or Director of Health and Wellness to conduct weekly room checks beginning 4/28/25 to ensure that residents with prescribed medications in their room are able to self medicate. Executive Director is responsible for maintaining compliance.

181c - Self-administration Assessment (continued)

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: All staff will be trained in the requirements of medication self administration.

Directed Completion Date: *05/31/2025*

182c - Medication Administration

3. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

Interviews with Staff person A and B indicated that the staff will administer all the residents medications, then come back to the Medication Administration Record (MAR) and initial the medications as administered all at once, rather than individually as required. This practice was observed while on site by Department Representatives. The staff persons are not following the proper steps of medication administration.

Plan of Correction ***Directed (█ - 04/28/2025)***

Executive Director immediately did a verbal in-service with med tech and nurse on the 5 medication rights. Executive Director conducted an in-service beginning on 4/11/2025 instructing the med techs and nurses and on the 5 medication rights. Beginning 4/11/2025, all staff were in-serviced on having only one resident at a time in the wellness room so that staff can focus on the 5 rights. Individual re-training to begin the week of 4/27/25 and continue until all med techs and nurses have been re-trained. Executive Director and Human Resources are in the process of hiring more medication technicians to enable more support for medication passes. Executive Director and Director of Health and Wellness are responsible for maintaining compliance by conducting the re-training, hiring of additional staff members, and continuing education on one resident at a time in the wellness room.

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: The administrator/designee will observe medication passes weekly on different days of the week, different shifts and with different staff for 3 months. These observations will be documented and immediate remediation will be completed.

Directed Completion Date: *05/31/2025*

184a - Resident's Meds Labeled

4. Requirements

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

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

Description of Violation

Resident #3's MAR notes potassium CL ER 20 MEQ tablets take 2 tablets by mouth three times daily and Saturday take 3 tablets. The label of the medication notes Sunday take 3 tablets. The label of the medication is incorrect.

Resident #3's MAR notes prednisolone AC 1% eye drops one drop in operative eye four times daily. On 4/4/25 decrease to one drop twice a day for two weeks. The label of the medication notes four times daily for instill two sprays then twice daily. The label to the medication is incorrect.

Repeat Violation: 8/26/24, 5/31/24, 3/26/24 et al

Plan of Correction ***Directed (█ - 04/28/2025)***

Med Tech immediately called the pharmacy for a corrected label for resident # 3's eye drops. The label was delivered that evening and placed on the box of eye drops. Change in directions sticker immediately placed on Resident #3's potassium CL ER bottle. Executive Director immediately did a verbal education with LPN and med tech on 4/10/25 on labels matching the MAR and orders. In-service for the remainder of the med techs/nurse began on 4/11/25 by the Executive Director for checking labels to match the MAR and orders. Director of Health and Wellness and Executive Director is responsible for maintaining compliance by providing continuing education and continuing with weekly cart audits.

Proposed Overall Completion Date: 05/31/2025

(Directed)

In addition to the above noted plan: The administrator/designee will observe medication passes weekly on different days of the week, different shifts and with different staff for 3 months. These observations will be documented and immediate remediation will be completed.

Directed Completion Date: *05/31/2025*

185a - Implement Storage Procedures

5. 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's PRN acetaminophen 500 mg was not available at the time of the inspection.

Plan of Correction ***Directed (█ - 04/28/2025)***

PRN acetaminophen 500 MG for Resident #1 was ordered immediately on 4/10/2025 and delivered that evening. Executive Director immediately did a verbal in-service with LPN and med tech that if a PRN medication is listed on the MAR or there is an order for a PRN medication, it must be available in the cart at all times. Executive Director began in-servicing with remainder of the med techs and nurse for the same. Executive Director and Director of Health and Wellness will be responsible for maintaining compliance by continuing education, continuing cart audits along with re-training med techs and nurses.

185a - Implement Storage Procedures (continued)

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: The administrator/designee will audit all resident medications for accuracy. Once the initial audit is completed weekly audits will be completed for 3 months. The audits will be documented and any errors will be corrected immediately.

Directed Completion Date: *05/31/2025*

187a - Medication Record

6. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

Description of Violation

Resident #3's has an order for ondansetron 4 mg PRN every 8 hours. The medication was not listed on the MAR.

Resident #4's lispro and lantus does not have a diagnosis or purpose listed on the MAR.

Resident #5's humalog and lantus does not have a diagnosis or purpose listed on the MAR.

Resident #6's sertraline and clearlax powder does not have a diagnosis or purpose listed on the MAR

Repeat violation: 5/31/24; 3/26/24 et al.

Plan of Correction ***Directed (█ - 04/28/2025)***

All MARs were corrected immediately on 4/10/2025 by the LPN and med tech. An in service was completed by the Executive Director to re-educate the med techs and nurses on all items needed on a medication record. Director of Health and Wellness or Executive Director will conduct a weekly MAR audit beginning 4/29/25 and continuing until compliance is maintained. Executive Director and Director of Health and Wellness are responsible for maintaining compliance.

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: The administrator/designee will audit all resident MAR's for accuracy. Once the initial audit is completed weekly audits will be completed for 3 months. The audits will be documented and any errors will be corrected immediately.

187a - Medication Record (continued)

Directed Completion Date: *05/31/2025*

187b - Date/Time of Medication Admin.

7. Requirements

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

Description of Violation

The 9:00 a.m. medications for Resident #1, #3, #4, #6 and #7 were not intialed as administered at approximately 11:45 a.m on 4/10/25. An interview with Staff person A indicated the medications were administered but the staff person did not have time to initial the MAR's yet.

Repeat Violation: 10/17/24

Plan of Correction ***Directed (- 04/28/2025)***

Executive Director immediately did a verbal in-service with med tech and nurse on the 5 medication rights. Executive Director conducted an in-service beginning on 4/11/2025 instructing the med techs and nurses and on the 5 medication rights. Beginning 4/11/2025, all staff were in-serviced on having only one resident at a time in the wellness room so that staff can focus on the 5 rights.

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: The administrator/designee will observe medication passes weekly on different days of the week, different shifts and with different staff for 3 months. These observations will be documented and immediate remediation will be completed.

Directed Completion Date: *05/31/2025*

187c - Refusal of Medication

8. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #1 refused the prescribed fluoxetine 20 mg daily and hydrochlorothiazide 25 mg on 4/9/25 at 9:00 a.m. The prescriber was not notified regarding the refusals.

Repeat Violation: 5/31/24

Plan of Correction ***Directed (- 04/28/2025)***

LPN notified physician via telephone immediately on 4/10/25 of the refusals of medication for Resident #1. Executive Director conducted an in-service beginning on 4/11/2025 educating the remaining med techs/nurses of the need

187c - Refusal of Medication (continued)

to notify the prescribing doctor. Executive Director and Director of Health and Wellness are responsible for maintaining compliance by reviewing notes in PCC daily, continuing education with staff, verbally checking with staff on any medication refusals, and continued med cart audits.

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: The home will conduct a training with staff who administer medications on how to document a refusal on the MAR. This training will also include who is responsible to notify the prescriber regarding the refusal. The administrator/designee will have daily meetings for 3 months to make sure refusals are reported as required. These meetings will be documented.

Directed Completion Date: *05/31/2025*

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident #1 has an order for Eliquis 5 mg tablet take 1/2 tablet by mouth twice daily. The medication was not administered on 4/8/25 at 9:00 p.m., 4/9/25 at 9:00 a.m. and 9:00 p.m. and 4/10/25 at 9:00 a.m.

Resident #1 has an order for esomeprazole mag DR 40 mg daily. On 4/10/25 at 9:00 a.m. only 20 mg was administered.

Repeat Violation: 8/26/24, 5/31/24, 3/26/24 et al

Plan of Correction ***Directed ([redacted] - 04/28/2025)***

LPN notified physician via telephone immediately on 4/10/25 of medication error for Resident #1. Order received 4/11/2025 for esomeprazole mag DR 20 MG 2 tabs daily. Verbal order then received on 4/11/2025 by PCP to decrease to 20 MG 1 tab daily. Verbal education provided immediately by Executive Director on following prescriber's orders and missing medications. In-service by Executive Director for remainder of staff began on 4/11/2025 for missing medications. Executive Director and Director of Health and Wellness are responsible for maintaining compliance by continuing education, continued cart audits and re-training of staff.

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: The administrator/designee will audit all resident MAR's/orders for accuracy. Once the initial audit is completed weekly audits will be completed for 3 months. The audits will be documented and any errors will be corrected immediately.

Directed Completion Date: *05/31/2025*

188b - Medication Error Reporting

10. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident’s designated person and the prescriber.

Description of Violation

Resident #1 has an order for Eliquis 5 mg tablet take 1/2 tablet by mouth twice daily. The medication was not administered on 4/8/25 at 9:00 p.m. and 4/9/25 at 9:00 a.m. The prescriber was not notified regarding the medication errors.

Plan of Correction ***Directed (█ - 04/28/2025)***

LPN notified physician via telephone immediately on 4/10/25 of medication error for Resident #1. Pharmacy was immediately called to fill the prescription on 4/10/2025. Medication for resident #1 was delivered the evening of 4/10/2025. Executive Director conducted a verbal education with LPN and Med Tech that the PCP needs to be notified if a resident did not receive a medication due to not having it on hand. Executive Director began conducting an in-service with remaining med techs and nurse beginning on 4/11/2025 on notifying the PCP for a medication error. Executive Director and Director of Health and Wellness are responsible for maintaining compliance by reviewing notes in PCC daily, continuing education with staff, verbally checking with staff on any medication errors, and continued med cart audits.

Proposed Overall Completion Date: 05/31/2025

(Directed)
In addition to the above noted plan: The home will conduct a training with staff who administer medications on how to document a medication error on the MAR and what constitutes a medication error. This training will also include who is responsible to notify the prescriber regarding the error. The administrator/designee will complete daily meetings for 3 months to make sure medication errors are reported as required. These meetings will be documented.

Directed Completion Date: *05/31/2025*

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

Facility Information

Name: *MIFFLIN COURT* **License #**: *22206* **License Expiration**: *02/20/2025*

Address: *450 EAST PHILADELHIA AVENUE, SHILLINGTON, PA 19607*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *450 EAST PHILADELPHIA AVENUE OPERATIONS LLC*

Address: *450 EAST PHILADELPHIA AVENUE, SHILLINGTON, PA, 19607*

Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *59* **Waking Staff**: *44*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *02/07/2025*

Inspection Dates and Department Representative

02/07/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *47*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *14* **Residents Served**: *11*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

Have Mobility Need: *12* **Have Physical Disability**: *0*

Inspections / Reviews

02/07/2025 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/24/2025*

Inspections / Reviews *(continued)*

03/25/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/08/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *03/28/2025*

04/01/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/08/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *04/09/2025*

04/16/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *04/08/2025*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

81b - Resident Personal Equipment

1. Requirements

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

Description of Violation

The enabler bar located in Room 305 was loose and visibly left leaning approximately 3 inches from the side of the bed.

The enabler bar in room 323 was unattached to the resident's bed. The wooden plank that slides between the mattress and box spring was held in place by the weight of the mattress was exposed as it had pulled out from underneath.

Plan of Correction ***Accept (- 03/25/2025)***

The enabler bar in room 305 was immediately secured by the therapy director on 2/7/2025. The enabler bar for room 323 was removed immediately on 2/7/2025 by the therapy director as there was no proper way to secure it. Discharge order was sent immediately to the PCP on 2/7/2025. Therapy director is responsible for continued weekly audits of bed enabler bars and communicating to Executive Director any faulty enabler bars. Executive Director is responsible for continued compliance.

Licensee's Proposed Overall Completion Date: *03/24/2025*

Implemented (- 04/14/2025)

141b1 - Annual Medical Evaluation

2. Requirements

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

Description of Violation

Resident # 1's most recent medical evaluation was completed on

Resident # 2's medical evaluation completed is incomplete, there is nothing noted for immunization history and ability to self-administer medications.

Resident #3's medical evaluation completed is incomplete, there is nothing noted for immunization history.

Plan of Correction ***Accept (- 03/25/2025)***

Audit completed by the Executive Director 2/11/2025 for medical evaluations that were due. Audits completed 2/18/2025 and 2/19/2025 for missing items on medical evaluations. No missing items were found. Verbal orders received for Resident number 2 and resident number 3 on 2/11/2025 to add missing items from the medical evaluation. Resident number 1 was seen for her annual exam on 2/19/2025, Executive Director is responsible for conducting weekly Audits of due dates for medical evaluations. Executive Director is responsible for ensuring all items that are needed are on the medical evaluation. Executive Director is responsible for maintaining compliance.

Licensee's Proposed Overall Completion Date: *03/24/2025*

Implemented (- 04/14/2025)

185a - Implement Storage Procedures

3. 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 # 4 has an order for acetaminophen 325 mg, 1 tablet by mouth every 6 hours as needed for pain. This medication was not available at the time of the inspection.

Resident # 3 has an order for acetaminophen 325 mg, 1 tablet by mouth every 6 hours as needed for pain. This medication was not available at the time of the inspection.

Resident #2 has an order for Milk of Magnesia SUS 400mg/SML as needed. The medication was not available at the time of the inspection.

Resident # 6, has an order for blood glucose readings twice daily. On 1/21/25, at 7:46 a.m. the reading in the glucometer was 72, but it was incorrectly transcribed on the Medication Administration Record (MAR) as 71. On 1/29/25, at 7:58 a.m. the reading in the glucometer was 103, but it was incorrectly transcribed on the MAR as 163. On 1/30/25, at 5 p.m. the MAR noted a reading of 132, but there is no 5pm reading in the glucometer. On 1/31/25, at 5:01 p.m. the reading in the glucometer was 315, but it was incorrectly transcribed on the MAR as 318.

Repeat violation: 3/26/24 et al

Plan of Correction ***Accept (- 04/01/2025)***

PRN medications that were not available were ordered immediately on 2/7/2025. An in-service was completed on 2/11/2025 by the Executive Director on ensuring that any resident that has a PRN order has the medication available in the med cart at all times along with ensuring glucometer readings are transcribed correctly and taken properly as ordered. DHW or third shift to conduct weekly med cart audits to ensure PRN medications are available. Weekly cart audits began on 2/11/2025. DHW to conduct weekly glucometer audits to ensure readings are transcribed correctly. Weekly glucometer audits began 2/11/2025. DHW is responsible for maintaining compliance. DHW to observe med techs randomly to ensure proper procedure for obtaining and transcribing blood glucose readings.
On 3/26/2025 an in-service was done by Executive Director for a new check and balance sheet. Med Techs/nurses will need to complete this sheet at the end of their shift to verify that they have taken all blood sugars and have transcribed them correctly. Also on 3/26/2025, an in-service was done by DHW on how to retrieve the glucose reading from memory on the glucometer.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented (- 05/08/2025)

187a - Medication Record

4. Requirements

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

187a - Medication Record *(continued)*

4. Strength.
6. Dose.

Description of Violation

Resident #5's, MAR notes Olanzapine 5mg give 1 tablet by mouth daily. The medication label notes Olanzapine 5mg, give 1/2 tablet once daily. The MAR is incorrect.

Plan of Correction ***Accept (- 04/01/2025)***

The MAR was corrected on 2/11/2025. The med tech/DHW is responsible for conducting weekly med cart audits to ensure that all medication labels and MARs match. Med cart audits began on 2/11/2025. The DHW is responsible for maintaining compliance. An in-service was completed on 2/11/2025 on matching labels, orders and MAR. DHW to provide continuing education if needed.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented (- 05/08/2025)

187d - Follow Prescriber's Orders

5. Requirements

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

Description of Violation

Resident #6, has an order for blood glucose readings twice daily. The blood glucose reading was not completed on 1/30/25 at 5.p.m.

Resident # 5, has an order for Olanzapine 5mg, give 1/2 tablet daily. From 2/1-2/7/25 the home administered 1 tablet daily.

Repeat Violation: 8/26/24, 5/31/24, 3/26/24 et al

Plan of Correction ***Accept (- 04/01/2025)***

MAR was corrected on 2/11/2025 for resident number 5. Staff were in-serviced on 2/11/2025 on blood glucose readings and ensuring orders, labels on medications and the MAR are all correct. DHW/third shift to conduct weekly MAR to cart and order audits. Weekly med cart audits began 2/11/2025. DHW is responsible for maintaining compliance.
On 3/26/2025 an in-service was done by Executive Director for a new check and balance sheet. Med Techs/nurses will need to complete this sheet at the end of their shift to verify that they have taken all blood sugars and have transcribed them correctly. Also on 3/26/2025, an in-service was done by DHW on how to retrieve the glucose reading from memory on the glucometer. DHW to observe med techs randomly to ensure proper procedure for obtaining and transcribing blood glucose readings.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented (- 05/08/2025)

225c - Additional Assessment

6. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #1's most recent assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 03/25/2025)***

Resident number one had [redacted] assessment completed by the Executive Director on 2/10/2025. Audit completed weekly of RASPs by Executive Director starting 2/11/2025 and continuing. All RASPs are current and up to date. Executive Director is responsible for adding new residents to spread sheet and is responsible for maintaining compliance of RASPs per regulations.

Licensee's Proposed Overall Completion Date: *03/24/2025*

Implemented ([redacted] - 04/14/2025)

234a - Admission Support Plan

7. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident # 5, was admitted to the home's Secured Dementia Care Unit on [redacted] The home did not complete a support plan.

Plan of Correction ***Accept ([redacted] - 04/01/2025)***

RASP for resident number 5 was completed 2/10/2025 by the Executive Director. Executive Director will be responsible for checking all new Admission RASPs to ensure compliance. New admission for secured dementia unit on 3/18/2025. Executive Director completed RASP for new admission the morning of 3/21/2025.
Executive Director did an audit of all resident RASPs that began on 2/11/2025 and continued through the week. Executive Director checks daily on the spreadsheet created to ensure that RASPs are completed within the regulatory time frame. Executive Director is responsible for maintaining compliance.

Licensee's Proposed Overall Completion Date: *03/28/2025*

Implemented ([redacted] - 04/14/2025)

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

Facility Information

Name: *MIFFLIN COURT* **License #**: *22206* **License Expiration**: *02/20/2025*

Address: *450 EAST PHILADELHIA AVENUE, SHILLINGTON, PA 19607*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *450 EAST PHILADELPHIA AVENUE OPERATIONS LLC*

Address: *450 EAST PHILADELPHIA AVENUE, SHILLINGTON, PA, 19607*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/30/1987* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *52* **Waking Staff**: *39*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *12/11/2024*

Inspection Dates and Department Representative

12/03/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *41*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *N/A* **Capacity**: *14* **Residents Served**: *10*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *67*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

12/03/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/03/2025*

Inspections / Reviews *(continued)*

01/15/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/30/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *01/22/2025*

01/28/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/30/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *01/30/2025*

04/16/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *01/30/2025*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

29a SOPb1- Hospice Care: Doctor Certification

1. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

The home reported Resident #1 was receiving hospice services and actively dying. The resident was not evacuated in fire drills conducted on 10-20-24 at 945pm and 11-25-24 at 613am. The statement from the resident's physician did not note the resident was actively dying or would suffer a hastened death as a result of being evacuated in the fire drills.

Plan of Correction ***Accept (- 01/15/2025)***

An in-service was completed by the ED and given to staff on the requirements for a hospice resident NOT being evacuated on 12/13/24. Staff have been instructed that unless otherwise specified, all residents must evacuate during a fire drill. Fired drills have been conducted since with a full evacuation. The ED will be responsible for auditing the monthly fire drill logs and maintaining compliance. The fire drill logs are to be checked and audited every month with no end date and any discrepancies will be reported in QAPI. Mifflin COurt currently has no residents on hospice.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (- 02/10/2025)

29a SOPb2 - Hospice Care: Informed Consent

2. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

Resident #1 was not evacuated during fire drills conducted in the home on 10-20-24 at 945pm and 11-25-24 at 613am. No written informed consent was found in Resident #1's record to acknowledge the resident would not be evacuated during fire drills.

Plan of Correction ***Accept (- 01/15/2025)***

An in-service was completed by the ED and given to staff on the requirements for a hospice resident NOT being evacuated on 12/13/24. Staff have been instructed that unless otherwise specified, all residents must evacuate during a fire drill. Fired drills have been conducted since with a full evacuation. The ED will be responsible for auditing the monthly fire drill logs and maintaining compliance. The fire drill logs are to be checked and audited every month with no end date and any discrepancies will be reported in QAPI. Mifflin COurt currently has no residents on hospice.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (- 02/10/2025)

29a SOPb4 - Hospice Care: Inform Non-Participating

3. Requirements

2600.

29a SOPb4 - Hospice Care: Inform Non-Participating *(continued)*

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

Resident #1 was not evacuated during fire drills conducted in the home on 10-20-24 at 945pm and 11-25-24 at 613am. There is not documentation that during the fire drills, the one designated person at the home who has knowledge in advance of the fire drill went immediately to the room of Resident #1 and notified the affected resident and any staff person who attempted to evacuate the resident, that it was a fire drill, and the resident was not to be evacuated. Staff were interviewed and did not confirm that this occurred.

Plan of Correction ***Accept (- 01/15/2025)***

An in-service was completed by the ED and given to staff on the requirements for a hospice resident NOT being evacuated on 12/13/24. Staff have been instructed that unless otherwise specified, all residents must evacuate during a fire drill. Fired drills have been conducted since with a full evacuation. The ED will be responsible for auditing the monthly fire drill logs and maintaining compliance. The fire drill logs are to be checked and audited every month with no end date and any discrepancies will be reported in QAPI. Mifflin Court currently has no residents on hospice.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (- 02/10/2025)

29a SOPb6 - Hospice Care: Resident Evacuation

4. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

On 10-20-24 at 945pm and 11-25-24 at 613am, Resident # 1 did not evacuate during the fire drills. The following provisions under 29a(b) (1-4) were not met, requiring the resident to be evacuated during a fire drill.

Plan of Correction ***Accept (- 01/15/2025)***

An in-service was completed by the ED and given to staff on the requirements for a hospice resident NOT being evacuated on 12/13/24. Staff have been instructed that unless otherwise specified, all residents must evacuate during a fire drill. Fired drills have been conducted since with a full evacuation. The ED will be responsible for auditing the monthly fire drill logs and maintaining compliance. The fire drill logs are to be checked and audited every month with no end date and any discrepancies will be reported in QAPI. Mifflin COurt currently has no residents on hospice.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (- 02/10/2025)

29a SOPb10 - Hospice Care: Resident Assessment and Support Plan

5. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

29a SOPb10 - Hospice Care: Resident Assessment and Support Plan *(continued)*

Description of Violation

Resident #1's Resident Assessment and Support Plan (RASP) dated 10-2-24 was not updated to note the resident was actively dying and was not to be evacuated during fire drills and did not document the specific requirements under regulation 29 pertinent to the specific resident.

Plan of Correction ***Accept (█ - 01/15/2025)***

An in-service was completed by the ED and given to staff on the requirements for a hospice resident NOT being evacuated on 12/13/24. Staff have been instructed that unless otherwise specified, all residents must evacuate during a fire drill. Fired drills have been conducted since with a full evacuation. The ED will be responsible for auditing the monthly fire drill logs and maintaining compliance. The fire drill logs are to be checked and audited every month with no end date and any discrepancies will be reported in QAPI. Mifflin COurt currently has no residents on hospice.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (█ - 02/10/2025)

29a SOPb11 - Hospice Care: Records

6. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

11. Documentation of compliance with this section is to be kept in the fire drill record, as well as in the resident's record. The documentation is to include the following:
    i. A copy of the Department of Health license for the hospice agency.
    ii. Written certification by the physician as specified in paragraph (1).
    iii. Written informed consent as specified in paragraph (2).
    iv. Written documentation of the home's consideration of relocation of the resident's bedroom as specified in paragraph (3)

Description of Violation

The home reported Resident #1 is was receiving hospice services and actively dying. The resident was not evacuated during fire drills conducted by the home on 10-20-24 at 9:45pm and 11-25-24 at 6:13am. The following documents were not kept with the home's fire drill records:

i. A copy of the Department of Health license for the hospice agency.

ii. Written certification by the physician as specified in paragraph (1).

iii. Written informed consent as specified in paragraph (2).

iv. Written documentation of the home's consideration of relocation of the resident's bedroom as specified in paragraph (3)

Plan of Correction ***Accept (█ - 01/28/2025)***

An in-service was completed by the ED and given to staff on the requirements for a hospice resident NOT being evacuated on 12/13/24. Staff have been instructed that unless otherwise specified, all residents must evacuate during a fire drill. Fired drills have been conducted since with a full evacuation. The ED will be responsible for auditing the monthly fire drill logs and maintaining compliance. The fire drill logs are to be checked and audited every month with no end date and any discrepancies will be reported in QAPI. Mifflin COurt currently has no residents on hospice.

Licensee's Proposed Overall Completion Date: *01/21/2025*

Implemented (█ - 02/10/2025)

29a SOPb11 - Hospice Care: Records *(continued)*

81b - Resident Personal Equipment

7. Requirements

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

Description of Violation

Room 320 utilizes an enabler bar. The enabler bar was observed moving 6 inches right, left, and out from the bed. When the enabler bar moved out from the bed, it raised the mattress. The enabler bar was not secured correctly, posing a possible limb or head entrapment.

Plan of Correction ***Accept (- 01/28/2025)***

The enabler bar was fixed the same day, December 3, 2024. All enabler bars were checked and fastened securely by the ED, therapy, and maintenance on 12/3/2024 and 12/4/2024. The community established that our therapy department would be responsible for auditing the residents with enabler bars to ensure they are fastened appropriately. Any discrepancies will be reported to maintenance immediately for repair. The audits will begin 1/25 and are now established to be an ongoing monthly audit. All findings will be reported to the ED and maintenance director.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (- 04/14/2025)

82c - Locking Poisonous Materials

8. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 9:22am Licensing Representatives (LR's) noted an unlocked spray can of Lysol disinfectant spray in the homes Secured Dementia Care Unit (SDCU). The manufacturer's label indicated "contact poison treatment specialist immediately if large quantity has been ingested or inhaled." The residents residing in the SDCU are not assessed to safely handle and identify poisonous materials.

Repeat Violation 3-26-24 et al

Plan of Correction ***Accept (- 01/28/2025)***

Corrected while the surveyor was on site on 12/3/2024. The Memory Care Director will be responsible for weekly audits of poisonous materials beginning December 6, 2024. Staff were re-educated on 12/13/24 on poisonous materials. The Memory Care Director/
Designee will audit poisonous materials for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (- 02/10/2025)

97 - Elevators/Lifting Devices

9. Requirements

2600.
97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

The facility elevator certificate expired 10-31-24.

Plan of Correction ***Accept (- 01/15/2025)***

The elevator was inspected on 12/27/24. The maintenance director was educated on NOT having to wait for the state to do the inspection. We can use a 3rd party for our elevator inspections. The maintenance director will be responsible for auditing the inspections and maintaining compliance monthly for 12 months or until we meet compliance

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (- 02/10/2025)

Withdrawn 5/7/25

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.
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.

105g - Lint Removal and Duct Cleaning *(continued)*

Description of Violation

The laundry room on the 3rd floor had a layer of lint on top of the external dryer duct, posing a fire hazard.

Plan of Correction ***Accept (█ - 01/28/2025)***

The maintenance Director immediately removed all lint from within and around all facility dryers on 12/3/2024. An in-service was started on 12/13/24 for all staff. The housekeeping manager will be responsible for the daily checks of all dryers for lint and maintaining compliance. The maintenance manager will be responsible for weekly audits, beginning December 6, 2024, of all dryers and the audits will continue for 2 months or until compliance is met.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (█ - 02/10/2025)

141a - Medical Evaluation

12. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #5 was admitted to the home on █ The resident's most recent Documentation of Medical Evaluation (DME) was completed on █. There is no documentation the resident's initial DME was completed.

Repeat Violation 3-26-24 et al

Plan of Correction ***Accept (█ - 01/28/2025)***

Executive Director and Business office manager conducted chart audits on 12/5/2024 to ensure resident DMEs were in compliance. Old DMEs were found in thinned chart files when audits were completed. DHW was inserviced on proper thinning of charts. DHW to audit and correct all DME's. All admission DME's will be checked by the DHW in the time frame
specified per code. 3rd shift supervisor to audit charts with the monthly changeover for 3 months or until compliance is met. Executive Director is responsible for maintaining compliance.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (█ - 02/10/2025)

141a 1-10 Medical Evaluation Information

13. Requirements

2600.

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

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

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

Description of Violation

Resident #1's DME dated [redacted] did not have anything noted for special health or dietary needs.

Plan of Correction ***Accept ([redacted] - 01/28/2025)***

Staff nurse was responsible for fixing the DME on 12/4/2024. Staff nurse made proper adjustments to DME according to verbal orders by resident's doctor on 12/44/2024. DHW to audit and correct all DME's. All admission DME's will be checked by the DHW in the time frame specified per code. 3rd shift supervisor to audit charts with the monthly changeover for 3 months or until compliance is met. DHW is responsible for checking audits and maintaining compliance.

Licensee's Proposed Overall Completion Date: *01/21/2025*

Implemented ([redacted] - 03/03/2025)

141b1 - Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident #2's annual DME dated [redacted] does not indicate a height, weight, or if the resident requires body positioning or movement.

Resident #'4s most recent DME was completed on [redacted], the previous DME was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 01/28/2025)***

Executive Director created audit tool and log to ensure DME's are completed in the time frame specified per code on 12/6/2024. DHW to audit and correct all DME's for current residents. All admission DME's will be checked by the DHW in the time frame specified per code. 3rd shift supervisor to audit charts with the monthly changeover for 3 months or until compliance is met. DHW is responsible for checking audits and maintaining compliance.

Licensee's Proposed Overall Completion Date: *01/21/2025*

Implemented ([redacted] - 04/14/2025)

162c - Menus Posted

15. 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 12-3-24 the menus were posted through 12-7-24 at every location where menus were posted.

Plan of Correction ***Accept (█ - 01/28/2025)***

The violation was corrected immediately on 12/3/2024. An in-service was given to kitchen staff on 12/11/24 by the Senior Dining Director. The dining director will be responsible for auditing the menu postings, beginning December 6, 2024, for 3 months or until the dining staff can maintain compliance

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (█ - 02/10/2025)

185a - Implement Storage Procedures

16. 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 #3's glucometer reading was taken on 11-27-24 at 0730. The glucometer reading was 112 and was incorrectly recorded as 108 on the Medication Administration Record (MAR).

Plan of Correction ***Accept (█ - 01/28/2025)***

Executive Director provided verbal education to medication technicians on 12/3/2024 and 12/4/2024 on proper documentation of glucose readings. An in-service was provided for all nursing staff on 12/13/24 on proper documentation by the ED. MAR to Med audits will be conducted weekly by the DHW for 2 months or until compliance can be maintained. DHW is responsible for maintaining compliance.

Licensee's Proposed Overall Completion Date: *01/21/2025*

Not Implemented (█ - 04/14/2025)

187a - Medication Record

17. Requirements

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

Description of Violation

Resident #6 has an order for a multivitamin tablet. The strength of the medication 5000IU was listed on the medication label but was not listed on the resident's MAR.

187a - Medication Record (continued)

Plan of Correction ***Accept (- 01/28/2025)***

The medication technician immediately corrected the MAR on 12/3/2024. An audit was conducted on 12/13/24 by our charge nurse. An in service was also completed on 12/20/24 on transferring info to the MAR. The DHW will be responsible for doing monthly audits on MAR to Cart and Cart to MAR to ensure all items are being transferred appropriately moving forward for 3 months or until the community is compliant. DHW is responsible for maintaining compliance.

Licensee's Proposed Overall Completion Date: *01/22/2025*

Not Implemented (- 02/10/2025)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident #3 has an order for insulin to be administrated on a sliding scale: 1-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251 – 300 = 6 units, 301-350 = 8 units, 351 or greater. On 11-22-24 at 0730 the resident had a glucometer reading of 128, requiring no insulin units to be administered. According to the resident's MAR, there were 2 units of insulin administered.

Repeat Violation: 8-26-24, 5-31-24, 3-26-24 et al

Plan of Correction ***Accept (- 01/28/2025)***

ED was responsible for conducting an audit and in service on 12/18/24. The DHW will continue to audit the sliding scales for 6 months or until the community is in constant compliance. The ED will have a training set for sliding scales by an outside company to ensure the medication technicians are retrained. The DHW is responsible for maintaining compliance.

Licensee's Proposed Overall Completion Date: *01/22/2025*

Not Implemented (- 02/10/2025)

227g -Support Plan Signatures

19. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5's RASP dated is not signed by the resident. There is no documentation noting the resident refused or was unable to sign.

Repeat Violation: 3-26-24 et al

Plan of Correction ***Accept (- 01/15/2025)***

An audit was done on 12/13 of all RASPS in the community to ensure all required signatures were received. Due to

227g -Support Plan Signatures (continued)

the DHW being on leave, an in service was provided to the employee who has assumed the role in the interim on requirements for a RASP. Monthly audits will be conducted by the DHW or ED beginning 1/12/25 and will continue for 3 months or until the community can maintain compliance

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented (- 02/10/2025)