

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

November 3, 2025

[REDACTED]
SACRED HEART ASSISTED LIVING, LLC
[REDACTED]
[REDACTED]

RE: SACRED HEART SENIOR LIVING BY
THE CREEK
602 EAST 21ST STREET
NORTHAMPTON, PA, 18067
LICENSE/COC#: 20136

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/12/2025 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: SACRED HEART SENIOR LIVING BY THE CREEK **License #:** 20136 **License Expiration:** 09/29/2025
Address: 602 EAST 21ST STREET, NORTHAMPTON, PA 18067
County: NORTHAMPTON **Region:** NORTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: SACRED HEART ASSISTED LIVING, LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 07/12/2000 **Issued By:** L & I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 83 **Waking Staff:** 62

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 08/12/2025

Inspection Dates and Department Representative

08/12/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 124 **Residents Served:** 68

Secured Dementia Care Unit

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

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 0
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 15 **Have Physical Disability:** 0

Inspections / Reviews

08/12/2025 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/12/2025

09/23/2025 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 10/22/2025
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/30/2025

Inspections / Reviews *(continued)*

10/15/2025 POC Submission

Submitted By: [REDACTED] Date Submitted: 10/22/2025

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 10/17/2025

11/03/2025 Document Submission

Submitted By: [REDACTED] Date Submitted: 10/22/2025

Reviewer: [REDACTED] Follow Up Type: Not Required

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At approximately 9:54 a.m., the laptop on the Med-Cart, located on the 3rd floor was unlocked, unattended and accessible to Resident records.

Plan of Correction

Accept [REDACTED] - 10/15/2025)

17. Record Confidentiality

Plan of Correction

Regulation Violated: §2600.17 – Confidentiality of Records

Resident records shall be confidential and may not be accessible to anyone other than authorized individuals without written consent, except in emergencies.

Violation Summary:

A Med tech's laptop used for electronic medication administration was left unattended and unlocked on the third-floor medication cart during a med pass. This exposed confidential resident information to unauthorized access, resulting in noncompliance with §2600.17. The privacy screen setting was set at 5 minutes until screen went into block mode.

Corrective Action Steps:

1. Immediate Response

- o The unattended laptop was promptly secured and locked upon discovery.*
- o The Med Tech involved was verbally counseled on the importance of maintaining confidentiality and proper device handling, including use of the sunglasses privacy icon.*

2. Staff Re-Education

- o All med tech staff received immediate instruction on electronic record security protocols, including:*
 - ? Locking screens when stepping away from devices*
 - ? Never leaving devices unattended without being in privacy mode*
 - ? Limit the time that unattended Med carts are in resident-accessible areas*
 - ? Reporting any breaches or lapses immediately to the Floor Nurse, Shift Supervisor or Director of Nursing.*
 - ? Using the privacy screen feature: Staff were reminded to click the sunglasses icon in the upper right corner of the Med Pass screen. When activated, the screen switches to privacy mode, preventing any resident information from being visible or accessible.*

3. Policy Reinforcement

- o Staff were reminded of their responsibility to protect resident information at all times, especially during medication administration and device use.*
- o Privacy screen mode operations were reviewed with Med Techs to ensure they understand how to activate and use the feature correctly during med passes.*

4. Technical Safeguards

- o Auto-lock settings on all medication laptops have been adjusted to activate after 1 minute of inactivity.*

17 Record Confidentiality (continued)

- o A photo of the Medication System Settings screen, showing the adjustment to 1 minute auto lock, has been completed. Photo is included to document screen setting.
- o Password complexity and timeout settings were reviewed to ensure compliance with PCH Regulations and facility standards.

Monitoring Plan:

- Oversight

The Administrator will maintain communication with the Director of Nursing to ensure continued compliance with confidentiality protocols and device usage. Administrator instructed Director of Nursing to change auto lock screen time from 5 minutes to 1 minute. Continued compliance will monitor that one minute will meet compliance.

- Weekly Spot Audits

Weekly audits of med cart stations will be conducted by the LPN Floor Nurse and Shift Supervisor to ensure laptops are properly secured when not in active use.

- Training Refreshers

Confidentiality, device security, and use of privacy screen features will be included in Med Tech staff training sessions and during Shift change reporting.

Responsible Parties:

- Administrator Department oversight and compliance
- Director of Nursing Staff instruction, technical safeguards, compliance with facility protocol
- LPN Floor Nurse & Shift Supervisor Weekly spot audits and compliance with facility protocol
- Med Pass Staff Daily compliance with confidentiality procedures

Licensee's Proposed Overall Completion Date: 09/29/2025

Implemented [redacted] - 11/03/2025)

82a - Poisonous Materials

2. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

According to the Personal Care staff, the small can sitting on the counter located in the common use bathroom outside of the dining area is Uline Citrus Blossom Air Freshener. The can did not have any label and the original product labeling was not available.

Plan of Correction

Accepted [redacted] - 10/15/2025)

82a Poisonous Materials

Plan of Correction

Regulation Violated: §2600.82a Chemicals must be stored in a locked area and labeled.

Violation Summary:

An unlabeled aerosol can of air freshener was found in the first floor common use bathroom, accessible to residents. This item was not properly labeled or secured, resulting in noncompliance with §82a.

82a - Poisonous Materials (continued)

Corrective Action Steps:

1. Immediate Disposal

o The unlabeled aerosol air freshener was promptly removed and disposed of upon discovery to eliminate any potential risk to residents.

2. Inventory Inspection

o The Director of Housekeeping inspected all remaining air freshener cans in stock.

o Each was confirmed to have secure manufacturer labels indicating contents and safety information.

3. Staff Instruction

o The Director of Housekeeping personally informed all housekeeping staff of the procedures for proper handling and storage of chemical aerosol products.

o Staff was reminded that all chemical items must remain labeled and stored in designated locked areas when not in use.

4. Product Replacement

o Aerosol air fresheners will no longer be used in common use bathrooms.

o A non-chemical plug-in scented unit has been installed to maintain odor control without introducing hazardous materials.

Monitoring Plan:

• Daily Oversight

The Administrator maintains daily communication with the Director of Housekeeping; specific reporting will include actions taken to ensure continued compliance with chemical storage procedures and product usage.

• Monthly Inventory Review

The Director of Housekeeping will continue monthly reviews of chemical inventory to confirm labeling and secure storage.

Responsible Parties:

• Administrator – Daily oversight and compliance with Housekeeping protocol

• Director of Housekeeping – Inventory inspection, staff instruction, and product management, daily walk-thru inspection of storage areas, common areas and hskpg staff's cleaning carts.

Licensee's Proposed Overall Completion Date: 09/29/2025

Implemented [redacted] - 11/03/2025)

82c - Locking Poisonous Materials

3. 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 2:13 p.m., Aim toothpaste and Olay Complete moisturizer with a manufacture's label indicating " Call Poison Control if Swallowed ", was unlocked, unattended, and accessible to residents in the home. Not all the residents of the home, including Resident [redacted], have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [redacted] 10/15/2025)

82c Locking Poisonous Materials (continued)*82c. Locking Poisonous Materials (continued)**Plan of Correction*

Regulation Violated: §2600.82c Poisons shall be stored in a locked area when accessible to a resident who is not able to safely use or avoid poisonous materials due to a physical or mental condition.

Violation Summary:

During inspection, resident's toiletries including toothpaste and Olay moisturizer both labeled with "Call Poison Control if swallowed" were found unlocked and unattended in an area accessible to a resident diagnosed with advanced dementia. This resident had been previously assessed as unable to safely avoid poisonous materials, resulting in noncompliance with §82c. This resident is not capable of reaching for any toiletries located in [REDACTED] bathroom or room. Care staff completes full care for this resident.

*Corrective Action Steps:**1. Immediate Removal and Securing of Items*

- o All toiletries labeled with poison warnings were immediately removed from accessible areas and secured in [REDACTED] locked bathroom vanity cabinet.*
- o The Maintenance Director installed a key lock on the resident's bathroom vanity to ensure secure storage of personal care items. Additional toiletries not used were returned to the daughter for removal from [REDACTED] room.*
- o The key is accessible only to care staff, with an additional key provided to the resident's daughter for family access. Resident is unable to access the vanity key.*
- o The resident's daughter was informed of the violation and instructed to place all toiletries in the locked vanity, use the key provided, and ensure the vanity remains locked at all times.*
- o Any questions or concerns from the family may be directed to the Administrator or Director of Nursing.*

2. Resident Specific Risk Review

- o A review of all residents' poison avoidance assessments was conducted.*
- o Only one other resident was identified as unable to safely avoid poisonous substances.*
- o And this other resident has since been transferred to a secured Memory Care Unit due to broader dementia related needs.*

3. Staff Instruction and Reinforcement

- o Direct care staff were instructed to put all toiletries and other products in the locked vanity. Care staff were reminded that any item labeled with poison warnings must be stored in a locked area if accessible to at risk residents.*
- o Care Staff were instructed to check labels on all personal care items and report any questionable products to the Administrator or Director of Nursing.*

4. Community wide Safety Sweep

- o A full sweep of resident accessible areas throughout the community was completed to ensure no unsecured poisonous materials remained.*
- o Housekeeping and care staff were assigned to conduct daily checks of rooms and bathrooms of any residents assessed as unable to avoid poisonous substances.*

*Monitoring Plan:**• Daily Room & Bathroom Checks*

Direct care staff and assigned Housekeeping staff will perform daily inspections of rooms and bathrooms for residents identified as unable to avoid poisonous materials. Any unsecured items will be removed immediately and reported.

82c - Locking Poisonous Materials (continued)

• Weekly Safety Audits

LPN Floor Nurse and Shift Supervisor will conduct weekly audits of all resident-accessible areas to ensure compliance with poison storage protocols.

• Risk Review

The Administrator and Admissions Director will review poison risk assessments during initial admission and during annual Medical Evaluation appointments to ensure new or any changes in resident cognitive status are reflected in care plans and storage procedures.

• Staff Training

Regulation §82c and poison safety protocols are included in training sessions with emphasis on label recognition and resident-specific precautions.

Responsible Parties:

- Administrator – Oversight of compliance and risk reviews during community walk thru conducted weekly
- Director of Nursing and Assistant Director of Nursing – Staff instruction and care plan updates
- Maintenance Director – Installation and maintenance of secure storage, key compliance and accessibility
- LPN Floor Nurse & Shift Supervisor – Weekly safety audits
- Direct Care Staff and Housekeeping staff – Daily room and bathroom checks for at-risk residents

Licensee's Proposed Overall Completion Date: 09/29/2025

Implemented [redacted] - 11/03/2025)

105g - Lint Removal and Duct Cleaning

4. 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.

Description of Violation

At approximately 9:40 a.m. The rocks located outside the home underneath the dryer vent were observed to be covered in a layer of lint approximately 1/8 of an inch thick.

Plan of Correction

Accept [redacted] - 10/15/2025)

105g. and 125a. Lint Removal and Duct Cleaning / Combustible Storage

Plan of Correction

Regulations Violated:

- §2600.105g – Laundry: 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.
- §2600.125a – Fire Safety: The home shall be maintained in a manner that protects the health, safety, and well-being of the residents.

Violation Summary:

An accumulation of dryer lint approximately 1/8 inch thick was observed on the rocks outside the home, on the ground, beneath the dryer vent. While the lint was several feet from any dryer or heat source, its was deemed in violation of 125a. Additionally, lint pieces were noted on the back panel of the interior dryer within 2 inches of the

105g - Lint Removal and Duct Cleaning (continued)

vent. These findings resulted in noncompliance with §105g and §125a.

Corrective Action Steps:

1. Immediate Cleaning and Removal

- o All visible lint was promptly removed from the outdoor area beneath the dryer vent and from the back panel of the interior dryer by Maintenance staff.
- o The surrounding area was inspected by Maintenance Director to ensure no additional lint accumulation remained.

2. Vent Maintenance Documentation

- o Vent cleaning procedures were reviewed and confirmed to be conducted daily and after each dryer use by Housekeeping Director, and all staff operating the dryers, including residents and family members.
- o A large print, clearly marked sign instructing individual to check and remove all lint after each use of dryer is posted at each dryer station.

3. Professional Vent Cleaning

- o The last annual professional dryer vent cleaning was completed on March 3, 2025 which included full duct system servicing.
- o The next scheduled cleaning is set annually. Documentation of annual service is retained for licensing review.

4. Staff Instruction and Accountability

- o All staff were reminded of the importance of lint removal and vent safety protocols.
- o Laundry/hskpg staff are required to conduct and document lint checks after each dryer use, including visual inspection of the back panel and surrounding area.
- o Any outdoor lint accumulation will be reported immediately to the Maintenance Director for removal.

Monitoring Plan:

• **Daily Lint Checks**

Staff using dryers will inspect and clean lint traps, drums, and surrounding areas after each use. Documentation will be maintained by Housekeeping Director.

• **Exterior Vent Inspections**

The Maintenance Director will inspect the outdoor vent area during monthly building checks and remove any lint accumulation.

• **Monthly Dryer Area Inspections**

The Maintenance Director will conduct monthly inspections of all dryer areas, including interior and exterior components, and remove any lint buildup not caught during daily or weekly checks.

• **Annual Professional Cleaning**

Dryer duct systems will continue to be professionally cleaned annually, with service dates documented and retained.

• **Staff Training**

Fire safety and dryer maintenance protocols will be reviewed with all staff, emphasizing compliance with §105g and §125a.

Responsible Parties:

- Administrator – Oversight and documentation from Housekeeping and Maintenance Directors
- Director of Housekeeping – Daily lint checks and staff instruction
- Maintenance Director – Monthly exterior inspections, monthly dryer area inspections, and coordination of professional cleanings
- All Staff Using Dryers – Daily compliance with lint removal protocols

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

Licensee's Proposed Overall Completion Date: 09/29/2025

Implemented (████) 11/03/2025)

125a - Combustible Storage

5. Requirements

2600.

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

Description of Violation

At approximately 9:35 a.m., multiple pieces of lint were observed on the back panel of the home's clothes dryer within 2 inches of the dryer vent.

Plan of Correction

Accept (████) 10/15/2025)

105g. and 125a. Lint Removal and Duct Cleaning / Combustible Storage

Plan of Correction

Regulations Violated:

- *§2600.105g Laundry: 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.*
- *§2600.125a Fire Safety: The home shall be maintained in a manner that protects the health, safety, and well being of the residents.*

Violation Summary:

An accumulation of dryer lint approximately 1/8 inch thick was observed on the rocks outside the home, on the ground, beneath the dryer vent. While the lint was several feet from any dryer or heat source, its was deemed in violation of 125a. Additionally, lint pieces were noted on the back panel of the interior dryer within 2 inches of the vent. These findings resulted in noncompliance with §105g and §125a.

Corrective Action Steps:

1. Immediate Cleaning and Removal

- o *All visible lint was promptly removed from the outdoor area beneath the dryer vent and from the back panel of the interior dryer by Maintenance staff.*
- o *The surrounding area was inspected by Maintenance Director to ensure no additional lint accumulation remained.*

2. Vent Maintenance Documentation

- o *Vent cleaning procedures were reviewed and confirmed to be conducted daily and after each dryer use by Housekeeping Director, and all staff operating the dryers, including residents and family members.*
- o *A large print, clearly marked sign instructing individual to check and remove all lint after each use of dryer is posted at each dryer station.*

3. Professional Vent Cleaning

- o *The last annual professional dryer vent cleaning was completed on March 3, 2025 which included full duct system servicing.*
- o *The next scheduled cleaning is set annually. Documentation of annual service is retained for licensing review.*

4. Staff Instruction and Accountability

- o *All staff were reminded of the importance of lint removal and vent safety protocols.*
- o *Laundry/hskpg staff are required to conduct and document lint checks after each dryer use, including visual*

125a - Combustible Storage (continued)

inspection of the back panel and surrounding area.

o Any outdoor lint accumulation will be reported immediately to the Maintenance Director for removal.

Monitoring Plan:

- Daily Lint Checks

Staff using dryers will inspect and clean lint traps, drums, and surrounding areas after each use. Documentation will be maintained by Housekeeping Director.

- Exterior Vent Inspections

The Maintenance Director will inspect the outdoor vent area during monthly building checks and remove any lint accumulation.

- Monthly Dryer Area Inspections

The Maintenance Director will conduct monthly inspections of all dryer areas, including interior and exterior components, and remove any lint buildup not caught during daily or weekly checks.

- Annual Professional Cleaning

Dryer duct systems will continue to be professionally cleaned annually, with service dates documented and retained.

- Staff Training

Fire safety and dryer maintenance protocols will be reviewed with all staff, emphasizing compliance with §105g and §125a.

Responsible Parties:

- Administrator – Oversight and documentation from Housekeeping and Maintenance Directors
- Director of Housekeeping – Daily lint checks and staff instruction
- Maintenance Director – Monthly exterior inspections, monthly dryer area inspections, and coordination of professional cleanings
- All Staff Using Dryers – Daily compliance with lint removal protocols

Licensee's Proposed Overall Completion Date: 09/29/2025

Implemented [redacted] 11/03/2025)

185a - Implement Storage Procedures

6. 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 [redacted] receives [redacted] on a sliding scale three times daily at 8:00 a.m. , 12:00 p.m. and 5:00 p.m. Resident's August 2025 medication administration record has conflicting information that indicates that [redacted] units and that [redacted] units of [redacted] were given on [redacted] at 8:00 a.m.

Plan of Correction

Accept [redacted] 10/15/2025)

185a. and 187d. Implement Storage Procedures / Follow Prescriber's Orders

Plan of Correction

Regulations Violated:

- §2600.185a – Resident Records: Resident records shall be current and include all required documentation.

185a Implement Storage Procedures (continued)

- §2600.187d Medication Records: The home shall follow the directions of the prescriber.

Violation Summary:

A discrepancy was noted in the resident's medication administration record (MAR) for Novolog insulin. The record appeared to show "2 units" administered on the sliding scale log, creating conflicting documentation. Upon investigation, it was confirmed that the correct physician ordered dose of 2 units of Novolog was administered. No additional insulin was required based on the resident's blood sugar readings, which did not meet the sliding scale threshold. The error was in documentation only, not in administration.

Corrective Action Steps:

1. Immediate Investigation and Confirmation

- o The Director of Nursing reviewed the MAR, physician orders, and blood glucose logs.
- o It was confirmed that the correct dose of 2 units of [REDACTED] was administered per physician orders.
- o No insulin was given in error, and no harm occurred to the resident.

2. Documentation Clarification

- o The Med Tech had correctly administered the insulin but mistakenly documented the 2 units on the sliding scale log, which should have reflected "0 units" (no additional insulin beyond the baseline dose).
- o The discrepancy was clarified in the resident's record, and the MAR was annotated to reflect the correct interpretation.

3. Medication Error Reporting

- o A Medication Error Report was completed and submitted to BHSL within 24 hours of the inspection, in accordance with protocol.
- o This report is attached to the Plan of Correction for review.

4. Staff Instruction and Reinforcement

- o Med Techs were re educated on proper documentation procedures for sliding scale insulin administration.
- o Staff were reminded that baseline doses and sliding scale adjustments must be recorded in their respective fields to avoid confusion.

5. Record Review Protocol

- o The Director of Nursing implemented a protocol for review of insulin administration, sliding scale input, accurate glucometer readings and documentation MARs to ensure clarity and accuracy in documentation.
- o Any inconsistencies will be addressed immediately and corrected with supporting documentation including complete reporting to DON.

Monitoring Plan:

- Audit of Diabetic Records

Blood Sugar / Diabetic Records Med Tech (SS) will conduct monthly or more frequent audits of diabetic resident records to ensure compliance with physician orders and documentation standards.

- Staff Training

Medication documentation protocols, including sliding scale insulin procedures, will be reviewed with all med pass staff, specific detailed training for all NEW Med Techs. Any Med Tech with repeated infractions on Diabetic documentation will review Med course and receive further training by ADON / Medication Trainer

Responsible Parties:

- Administrator & Admissions Director Submission of documentation to BHSL and oversight of compliance of Reportable Incident Reports
- Director of Nursing Investigation, staff instruction, and MAR review

185a Implement Storage Procedures (continued)

- Blood Sugar / Diabetic Records Med Tech Monthly audits of Blood sugar readings, glucometer input, and accurate documentation
- Med Tech Staff Daily compliance with documentation protocols

Licensee's Proposed Overall Completion Date: 09/29/2025

Implemented (█) - 11/03/2025)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident █ is prescribed █ for blood glucose levels on a sliding scale. The order indicates that no Units of █ are to be administered for blood glucose levels less than 200. On █ at 8:00 a.m. the blood glucose reading was █ and resident █ was administered █ of █.

Plan of Correction

Accept (█) - 10/15/2025)

185a. and 187d. Implement Storage Procedures / Follow Prescriber's Orders
Plan of Correction

Regulations Violated:

- §2600.185a Resident Records: Resident records shall be current and include all required documentation.
- §2600.187d Medication Records: The home shall follow the directions of the prescriber.

Violation Summary:

A discrepancy was noted in the resident's medication administration record (MAR) for █ insulin. The record appeared to show "2 units" administered on the sliding scale log, creating conflicting documentation. Upon investigation, it was confirmed that the correct physician ordered dose of 2 units of Novolog was administered. No additional insulin was required based on the resident's blood sugar readings, which did not meet the sliding scale threshold. The error was in documentation only, not in administration.

Corrective Action Steps:

1. Immediate Investigation and Confirmation

- o The Director of Nursing reviewed the MAR, physician orders, and blood glucose logs.
- o It was confirmed that the correct dose of 2 units of █ was administered per physician orders.
- o No insulin was given in error, and no harm occurred to the resident.

2. Documentation Clarification

- o The Med Tech had correctly administered the insulin but mistakenly documented the 2 units on the sliding scale log, which should have reflected "0 units" (no additional insulin beyond the baseline dose).
- o The discrepancy was clarified in the resident's record, and the MAR was annotated to reflect the correct interpretation.

3. Medication Error Reporting

- o A Medication Error Report was completed and submitted to BHSL within 24 hours of the inspection, in

187d Follow Prescriber's Orders (continued)

accordance with protocol.

o This report is attached to the Plan of Correction for review.

4. Staff Instruction and Reinforcement

o Med Techs were re educated on proper documentation procedures for sliding scale insulin administration.

o Staff were reminded that baseline doses and sliding scale adjustments must be recorded in their respective fields to avoid confusion.

5. Record Review Protocol

o The Director of Nursing implemented a protocol for review of insulin administration, sliding scale input, accurate glucometer readings and documentation MARs to ensure clarity and accuracy in documentation.

o Any inconsistencies will be addressed immediately and corrected with supporting documentation including complete reporting to DON.

Monitoring Plan:

• **Audit of Diabetic Records**

Blood Sugar / Diabetic Records Med Tech (SS) will conduct monthly or more frequent audits of diabetic resident records to ensure compliance with physician orders and documentation standards.

• **Staff Training**

Medication documentation protocols, including sliding scale insulin procedures, will be reviewed with all med pass staff, specific detailed training for all NEW Med Techs. Any Med Tech with repeated infractions on Diabetic documentation will review Med course and receive further training by ADON / Medication Trainer

Responsible Parties:

• **Administrator & Admissions Director** *Submission of documentation to BHSL and oversight of compliance of Reportable Incident Reports*

• **Director of Nursing** *Investigation, staff instruction, and MAR review*

• **Blood Sugar / Diabetic Records Med Tech** *Monthly audits of Blood sugar readings, glucometer input, and accurate documentation*

• **Med Tech Staff** *Daily compliance with documentation protocols*

Licensee's Proposed Overall Completion Date: 09/29/2025

Implemented ██████████ **- 11/03/2025)**