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

May 13, 2026

[redacted], PRESIDENT
ASBURY HEALTHCARE, LLC
[redacted]

RE: ASBURY HEALTH CENTER
700 BOWER HILL ROAD
PITTSBURGH, PA, 15243
LICENSE/COC#: 45550

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/12/2026, 02/13/2026 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: *ASBURY HEALTH CENTER* **License #**: *45550* **License Expiration**: *04/01/2026*

Address: *700 BOWER HILL ROAD, PITTSBURGH, PA 15243*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *ASBURY HEALTHCARE, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/09/1991* **Issued By**: *Labor and Industry*

Type: *C-2 LP* **Date**: *02/27/1989* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *70* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *02/13/2026*

Inspection Dates and Department Representative

02/12/2026 - On-Site: [redacted]

02/13/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *43*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *6th floor* **Capacity**: *24* **Residents Served**: *19*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

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

Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

02/12/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/12/2026*

Inspections / Reviews *(continued)*

03/18/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/13/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/24/2026*

03/25/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/13/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/13/2026*

05/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/13/2026*

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

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

On 1/30/26 at approximately 6:30pm, resident #1 was administered 30 units of insulin lispro instead of 30 units of Toujeo insulin. The home did not report this incident to the Department until 2/2/26 at approximately 8:00am.

Plan of Correction ***Directed (- 03/25/2026)***

Regarding this violation the Administrator was not made aware of this Med Error until after 24 hours had passed. Therefore, Administrator trained the LPN's and any other lead med techs on what a reportable incident is and how to report it, if necessary, as per regulation 2600.16c. The protocol is now to call administrator and or Resident Care Coordinator (RCC) immediately if a reportable incident occurs. Depending on severity the administrator or RCC will instruct the staff to complete a reportable incident form or not and next steps which may include completing an ACT 70, calling the medical provider and so on. This education was held on 03/09/2026 by the administrator and the RCC. (DIRECTED: Documentation of the staff education shall be kept. 3/25/26). Administrator created an example ACT 70 reportable, example Reportable Incident Form, and left tips and pointers on what to write, how to submit, and to whom to submit to. This example packet is being kept in the nurse's office on the 6th floor by the computer. For long-term compliance administrator created an area on the 24-hour report where the Nurse / MT on duty will document any reportable incidents. Staff hold a daily shift huddle where all information is gone over, additionally the Resident Care Coordinator verifies this information. Facility scheduled an internal Quality Management Meeting in addition to the previously scheduled staff meeting held on March 19th, 2026. (DIRECTED: Documentation of the quality management review shall be kept. 3/25/26)

DIRECTED: Beginning on 3/30/26: The administrator/designee shall review all internal incidents daily to ensure all incidents specified in 2600.16a are reported to the Department within 24 hours in accordance with 2600.16c. 3/25/26

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *03/30/2026*

Implemented (- 05/13/2026)

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 2/12/26 at 10:27am, the locking device was missing from the door of the left side bathroom stall in the common bathroom #3603.

Plan of Correction ***Accept (- 03/18/2026)***

Regarding this violation, the lock was fixed immediately upon the finding by the maintenance department. Moving

42s - Privacy (continued)

forward administrator and or designee will complete daily environmental rounds to ensure there are locks in all shared bathrooms. This audit will begin on 3/9/26 and will be completed daily, this audit will check not only locks but ensure that all other privacy measures are met, including shower curtains etc.. to ensure items of regulation 2600.42s are met. This audit will be completed for three weeks then move to 3 times a week audit for an additional 3 weeks.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented (- 05/13/2026)

65i - Training Record

3. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training for "Initial Assessment (preadmission screening), Annual Assessment (DME) and Support Plan (RASP)" training for direct care staff member A does not include the date, source or the length of the course.

Plan of Correction ***Directed (- 03/25/2026)***

Prior to this violation, annual training was changed to no longer be on paper. All annual training will be completed online through Relias to ensure all educational requirements are met per regulation 2600.65i. Administrator and or designee will monitor monthly to ensure staff members are kept up to date this is monitored through Relias and will be checked on the last Friday of each month beginning March 27, 2026. (DIRECTED: During the monthly reviews, the administrator/designee shall ensure a record of training is present for all completed trainings in accordance with 2600.65i. 3/25/26). Administrator worked with corporate to ensure all training requirements are met. Should there be any additional training throughout the year the facility will complete that training on paper and will be filed within the team members personnel files.

DIRECTED: By 3/31/26: The administrator shall update staff person A's "Initial Assessment (preadmission screening), Annual Assessment (DME) and Support Plan (RASP)" training to include the date, source and the length of the course. A copy of the updated training record shall be kept in staff person A's record. 3/25/26

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *03/31/2026*

Implemented (- 05/13/2026)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/30/26 at approximately 6:30pm, resident #2's insulin lispro pen, opened on 1/27/26, was used to administer insulin to resident #1. Additionally, resident #2's insulin lispro pen continued to be used daily between

85a - Sanitary Conditions (continued)

1/31/26-2/13/26 by resident #2 after it was used on resident #1.

On 2/12/26 at the following times, there was a thick layer of dust coating the ceiling vents in the following locations:

- At 10:31am in the common bathroom #3604
- At 10:34am in the common shower room beside bathroom #3604
- At 10:38am in common bathroom #3603

On 2/12/26 at 11:20am, there was a brown substance that appeared to be feces, measuring approximately 1" in length, on the outside of the toilet seat riser in common bathroom #3504.

On 2/12/26 at 1:35pm, there were numerous loose frozen pretzels, frozen mixed vegetables and other food debris littering the floor under the right-hand side shelving unit in the walk-in freezer in the home's main kitchen.

REPEAT VIOLATION: 2/26/2025

Plan of Correction ***Directed ([redacted] - 03/25/2026)***

Immediately upon the finding of the dirty vents and the apparent feces housekeeping was called and all areas were cleaned properly. Due to this violation the administrator will institute daily environmental rounds which will include but not be limited to shared bathrooms, the kitchens on Level 5 and 6, and shower rooms, to ensure compliance is met in regulation 2600.85a. These daily audits will begin on 3/9/26 and will continue daily for 3 weeks then move to 3 times per week for 3 weeks, then move to 5 times per week for 3 weeks to ensure compliance, these audits will be completed by the administrator and or designee.
Regarding frozen pretzels, vegetables and other food debris Dietary Manager [redacted] held a staff huddle on 3/9/26 to explain various dietary regulations and requirements as per the 2600 chapter including 2600.103d, 2600.85a, 2600.103f, etc. Also, the administrator and the dietary manager now hold monthly meetings 2x a month to go over various topics, concerns etc.
Sanitary conditions must be met for compliance with insulin and diabetic supplies; therefore, administrator held an education for all Med Techs to go over various areas of sanitary conditions when passing meds including, not using shared glucometers, shared needles, creams, lotions etc.. This education was held on 3/9/26 in the nurse's office. (DIRECTED: Documentation of the staff education shall be kept. [redacted] 3/25/26).
The insulin pen was disposed of on Monday February 2, 2026, at the cost of the facility. When the incident of the shared pen occurred, staff contacted the primary physician and notified them, there were no instructions given or additional orders given other than to send resident number 1 to the hospital for a general evaluation.
Administrator scheduled required Diabetic re-education for all Med Techs on April 3, 2026, with a diabetic educator. (DIRECTED: Documentation of the staff education shall be kept. [redacted] 3/25/26). Moving forward, the nurse on duty will perform random spot checks of all med techs dispensing insulin daily to ensure accuracy moving forward. These spot checks started on March 16, 2026

DIRECTED: Beginning on 3/30/26: The administrator/designee shall inspect all resident insulin supplies weekly for 1 month then monthly thereafter to ensure supplies are clearly labeled with the resident's name, including open insulin pens, and are stored in an organized manner. Documentation of the audits shall be kept for 1 month. [redacted] 3/25/26

DIRECTED: Beginning on 3/30/26: The administrator/designee shall observe each staff person responsible for diabetic care perform blood glucose checks and administer insulin. Each staff person shall be observed once per week for 3 months. After which, each staff person will be observed once per month for 3 months. Documentation

85a - Sanitary Conditions (continued)

of all observations shall be kept. [redacted] 3/25/26

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *04/13/2026*

Implemented ([redacted] - 05/13/2026)

88a - Surfaces

5. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/12/26 at 11:25am, there were 2 sections of drywall measuring approximately 8"x10" each missing from the wall and exposing pipes in the first bathroom stall from the door in the common bathroom by the clean linen closet #3505.

Plan of Correction ***Accept ([redacted] - 03/25/2026)***

Immediately upon the finding of the missing pipes and exposed drywall the maintenance department fixed this area. Due to this violation the administrator will institute daily environmental rounds which will include but not limited to shared bathrooms, the kitchens on Level 5 and 6, and shower rooms to meet regulation 2600.88a. These daily audits will begin on 3/9/26 and will continue daily for 3 weeks then move to 3 times per week for 3 weeks. Additionally, all staff members were instructed and educated on how to call maintenance and call in a work order to ensure compliance is met, this education was held by the administrator on 3/10/26, and the education will be kept in the 6th floor nurses office for look back or reference.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented ([redacted] - 05/13/2026)

103d - Storing Food Off Floor

6. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 2/12/26 at approximately 1:30pm, there were 6 crates of iced tea stored on the floor in the dairy walk-in cooler in the home's main kitchen area.

Plan of Correction ***Accept ([redacted] - 03/18/2026)***

Immediately upon the finding of the iced tea on the floor the dietary department removed the iced tea and placed it on a shelf. Dietary Manager[redacted] held a staff huddle on 3/9/26 to go various dietary regulations including 2600.103d, 2600.85a, 2600.103f, 2600.103e. The administrator and the dietary manager now hold monthly meetings 2x a month to go over various topics, concerns etc. Dietary Manager will oversee the main kitchen for continued compliance and the administrator and or designee will oversee the compliance of the small kitchens on levels 5 and 6. This will be completed by environmental rounding and documenting any issues or concerns. Daily environmental rounds will be completed on levels 5 and 6 by administrator and or designee and three-time weekly environmental rounds by the [redacted] Dietary department in the main kitchen, this audit will begin 3/9/26 and continue for 3 weeks.

103d - Storing Food Off Floor *(continued)*

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented ([redacted] - 05/13/2026)

127a - Portable Space Heaters

7. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 2/12/26 at approximately 11:00am, a Lasko brand portable space heater was in use on the window sill in resident #3's bedroom.

Plan of Correction ***Directed ([redacted] - 03/25/2026)***

Immediately upon the finding of the portable space heater, it was removed and placed in the administrator's office. (DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall ensure the portable space heater is removed from the home. [redacted] 3/25/26). Daily environmental rounds will be completed for all resident rooms for 2 weeks starting 3/9/26 to ensure regulation 2600.127 is met and remains in compliance. Then the administrator and or designee will randomly select 10 residents per week to audit additionally. This audit will be completed by the administrator and or designee. Administrator contacted all residents' families via email which is facility main point of contact to inform them portable space heaters are prohibited within the facility. This email was sent out on 3/18/26.ed.

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *03/31/2026*

Implemented ([redacted] - 05/13/2026)

132a - Monthly Fire Drill

8. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of October 2025.

Plan of Correction ***Accept ([redacted] - 03/25/2026)***

Administrator met with the maintenance department to discuss the various violations including 2600.132a, 2600.132b, 2600.132d on March 3, 2026. During this meeting maintenance was re-educated on how to complete the fire drill log form accurately, and to ensure this portion of the regulations is met with compliance. The administrator will review the log each month within 48 hours of the drill to ensure accuracy and compliance. It was determined through discussion that there was a fire drill in October, but the fire drill log was incorrectly filled out and the wrong date was documented, which again to correct this the administrator will verify each month that the fire drill log is completed correctly beginning April 1, 2026. The administrator and maintenance department pre scheduled fire drills for the remainder of the year at various times, and dates to ensure that no missed fire drill occurs.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented ([redacted] - 05/13/2026)

132b - Safety Inspection/Fire Drill

9. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection and supervised fire drill conducted by a fire safety expert was held on 12/23/25, however, the previous fire safety inspection and supervised fire drill conducted by a fire safety expert was held on 3/28/24.

Plan of Correction ***Accept (- 03/25/2026)***

It was determined the reasoning behind the missed annual fire drill was due to a misunderstanding of regulation 2600.132b. Maintenance staff were reeducated that the supervised fire drill must be completed within a year of the last one not one supervised fire drill per calendar year. Administrator met with the maintenance department and the administrative assistant of the department to explain this regulation in depth and the importance of, this was completed on March 3, 2026.
The facility contacted the local fire department on March 18, 2026, to preschedule the supervised drill but unfortunately the fire department does not schedule that far out. Therefore, the administrative assistance set up a calendar invite to remind [redacted] and the administrator to call and schedule in September which is three months prior to the annual supervised drill being expired. The home currently does not have any kind of tracking system to ensure annual requirements are met; however, the administrator does plan on making an annual tracking system.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented (- 05/13/2026)

132d - Evacuation

10. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

From 4/12/25 through 12/23/25, the home did not have a maximum safe evacuation time specified in writing by a fire safety expert that exceeded 2 minutes and 30 seconds. According to the fire drill records, the home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

- *On 11/10/25 at 1:40am, the evacuation time was 3 minutes and 52 seconds*
- *On 8/26/25 at 2:00pm, the evacuation time was 3 minutes and 50 seconds*
- *On 7/22/25 at 2:30am, the evacuation time was 3 minutes and 52 seconds*
- *On 6/30/25 at 2:20pm, the evacuation time was 3 minutes and 0 seconds*
- *On 4/24/25 at 12:49am, the evacuation time was 3 minutes and 57 seconds*

Plan of Correction ***Directed (- 03/25/2026)***

Due to this violation administrator met with the maintenance department on March 3, 2026, to discuss this specific violation 2600.132d. During this meeting administration informed the maintenance department that various fire drills failed due to the evacuation time being greater than the 2:30 seconds which was allotted by the fire

132d Evacuation (continued)

department. Moving forward due to other violations administrator will verify all fire drill records within 48 hours of the drill being completed. (DIRECTED: The administrator review of all fire drill documentation shall begin on 4/1/26 to ensure compliance with 2600.132d. [redacted] 3/25/26). Should any drill not pass the facility will re complete the drill within 3 days. The home currently does not have any kind of tracking system to ensure annual requirements are met; however, the administrator does plan on making an annual tracking system.

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *04/01/2026*

Implemented ([redacted] - 05/13/2026)

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

Resident #3's most recent medical evaluation, dated [redacted], does not indicate the medical professional's determination whether the resident's needs can be met safely at the personal care home or if the resident is Nursing Facility Clinically Eligible (NFCE). That section of the form was blank.

Plan of Correction ***Directed ([redacted] - 03/25/2026)***

Once this violation was identified the administrator sent the DME to the Physician to have the Nursing Facility Clinically Eligible (NFCE) section completed dated to match his assessment date of 10/8/25 . To ensure all other DMEs have this section completed administrator and or designee will complete a weekly audit where 10 random residents will be selected and viewed for compliance and accuracy for regulation 2600.141b1. This Aduit will begin 3/9/26 and continue for 5 weeks or until all resident DME's have been audited for compliance. Previously the home had an administrative assistant who was overseeing the completion of the DME's and RASP's. That position has since been eliminated so to ensure compliance the night shift nurse who works 5 days a week will continue audits monthly. There will be a binder kept in the nurse's office where all audits and compliance will be kept.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall review resident #3's most recent medical evaluation to ensure it is completed in its entirety, including ensuring documentation is present on the medical evaluation indicating the needs of resident #3 can be safely met at the personal care home. A copy of resident #3's most recent medical evaluation shall be kept in resident #3's record. [redacted] 3/25/26

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *03/31/2026*

Implemented ([redacted] - 05/13/2026)

184a - Resident's Meds Labeled

12. 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 #2 is prescribed insulin lispro 100 units/ml-inject 4 units subcutaneously 3 times a day; however, the pharmacy label indicates inject 8 units subcutaneously 3 times a day.

Resident #1 is prescribed Levothyroxine Sodium 100mcg-give 1 tablet one time a day; however, the pharmacy label indicates take 1 tablet by mouth every morning, must be given on an empty stomach-at least an hour apart from meals and other medications- and at least 4 hours apart from other minerals.

Plan of Correction ***Directed (- 03/25/2026)***

Once it was known that the pharmacy label did not match Resident 2 immediately the resident care coordinator verified the correct dose of insulin and put a direction change sticker on this medication. Regarding the medication that did not have all the same instructions Resident care coordinator contacted pharmacy on date 2/16/26 and informed the pharmacy all information must match exactly, including but not limited to the extra ancillary information. The Levothyroxine label was updated and sent on 02/27/26 due to the date the last time the levothyroxine was filled. To ensure accuracy of regulation 2600.184a administrator will assign 5 residents weekly and have their orders printed from point click care and then verified through a check and balance system of what is in the cart. This audit will continue weekly until all residents are completed as a baseline audit so about 9 weeks then after the 9 weeks 10 residents will be chosen monthly to ensure continued compliance. Administrator also created generic "direction changed, refer to MAR" in case there are not stickers from the pharmacy available on March 16, 2026.

DIRECTED: By 4/6/26: The administrator shall re-educate all staff persons qualified to administer medications on proper medication administration procedures, which includes the home's procedures for updating pharmacy labels immediately upon receipt of a change order. Documentation of the staff education shall be kept. 3/25/26

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *04/06/2026*

Implemented (- 05/13/2026)

186b - Medication Used by Resident

13. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 1/30/26 at approximately 6:30pm, resident #1 was administered 30 units of insulin lispro 100 units/ml prescribed for and belonging to resident #2.

Plan of Correction ***Directed (- 03/25/2026)***

Due to this violation, administrator purchased pencil boxes for all residents who are diabetic to ensure all supplies for the correct resident are used correctly to ensure accuracy for 2600.18b and 2600.187d. Pencil boxes were also labeled with resident names on the outside and pencil boxes were purchased on March 9, 2026.
The Med Tech who made the medication error was reeducated on diabetics, will receive additional Observations by the Med Tech Train the Trainer March 24, 2026, and received a disciplinary action from Human Resources for the error. The facility also scheduled a Med class review with (Diabetes educator) for all med techs who

186b - Medication Used by Resident (continued)

are already diabetic certified as an refresher. (DIRECTED: By 4/3/26: All staff persons qualified to administer medications shall be re-educated by a Certified Diabetic Educator on proper blood glucose testing and insulin administration procedures, which includes ensuring no diabetic supplies, including insulin, are shared with other residents. Documentation of the staff education shall be kept. [redacted] 3/25/26). This class will be held in April, however in the meantime The shared insulin pen was disposed of by the Nurse on Duty. Facility reordered a new pen at the cost of the facility and it arrived 2/2/26. The Resident was not without insulin during this time as resident number 2 had another pen already in the facility.

Both medical doctors were informed of the incident; there was no recommendation from the physician other than to send resident number 1 for evaluation. Resident returned same night with no reactions or concerns from the additional, incorrect insulin.

Facility also trained Med techs, and nurses on reportable incidents and how to complete the appropriate paperwork if a med error occurs and administration is not on site. Med Techs were also reeducated on how devices, medications, supplies cannot be shared between others including glucometers, insulin pens, nebulizer supplies etc. This training was held and created by the administrator on 03/09/2026, this education will be kept in the nurses office on the 6th floor.

DIRECTED: Beginning on 3/30/26: The administrator/designee shall inspect all resident insulin supplies weekly for 1 month then monthly thereafter to ensure supplies are clearly labeled with the resident's name, including open insulin pens, and are stored in an organized manner. Documentation of the audits shall be kept for 1 month. [redacted] 3/25/26

DIRECTED: Beginning on 3/30/26: The administrator/designee shall observe each staff person responsible for diabetic care perform blood glucose checks and administer insulin. Each staff person shall be observed once per week for 3 months. After which, each staff person will be observed once per month for 3 months. Documentation of all observations shall be kept. [redacted] 3/25/26

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *04/13/2026*

Implemented ([redacted] - 05/13/2026)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #1 is prescribed Toujeo SoloStar insulin 300 unit/ml-inject 30 units subcutaneously at bedtime. However on 1/30/26 at approximately 630pm, resident #1 was administered 30 units of insulin lispro instead of 30 units of Toujeo insulin.

Plan of Correction ***Directed ([redacted] - 03/25/2026)***

See attached.Due to this violation, administrator purchased pencil boxes for all residents who are diabetic to ensure all supplies for the correct resident are used correctly to ensure accuracy for 2600.18b and 2600.187d. Pencil boxes were also labeled with resident names on the outside and pencil boxes were purchased on March 9, 2026.

The Med Tech who made the medication error was reeducated on diabetics, will receive additional Observations by

187d Follow Prescriber's Orders (continued)

the Med Tech Train the Trainer March 24, 2026, and received a disciplinary action from Human Resources for the error. The facility also scheduled a Med class review with [redacted] (Diabetes educator) for all med techs who are already diabetic certified as an refresher. (DIRECTED: By 4/3/26: All staff persons qualified to administer medications shall be re educated by a Certified Diabetic Educator on proper blood glucose testing and insulin administration procedures, which includes ensuring no diabetic supplies, including insulin, are shared with other residents. Documentation of the staff education shall be kept. [redacted] 3/25/26). This class will be held in April, however in the meantime

The shared insulin pen was disposed of by the Nurse on Duty. Facility reordered a new pen at the cost of the facility and it arrived 2/2/26. The Resident was not without insulin during this time as resident number 2 had another pen already in the facility.

Both medical doctors were informed of the incident; there was no recommendation from the physician other than to send resident number 1 for evaluation. Resident returned same night with no reactions or concerns from the additional, incorrect insulin.

Facility also trained Med techs, and nurses on reportable incidents and how to complete the appropriate paperwork if a med error occurs and administration is not on site. Med Techs were also reeducated on how devices, medications, supplies cannot be shared between others including glucometers, insulin pens, nebulizer supplies etc. This training was held and created by the administrator on 03/09/2026, this education will be kept in the nurses office on the 6th floor.

The facility will continue to randomly select residents to match their Medications to what the Doctor Order to ensure compliance is met.

DIRECTED: Beginning on 3/30/26: The administrator/designee shall review the medication administration records of at least 5 residents weekly for 1 month then monthly thereafter to ensure compliance with 2600.187d. [redacted] 3/26/26

DIRECTED: Beginning on 3/30/26: The administrator/designee shall inspect all resident insulin supplies weekly for 1 month then monthly thereafter to ensure supplies are clearly labeled with the resident's name, including open insulin pens, and are stored in an organized manner. Documentation of the audits shall be kept for 1 month. [redacted] 3/25/26

Proposed Overall Completion Date: 03/31/2026

Directed Completion Date: *04/13/2026*

Implemented ([redacted] - 05/13/2026)