

Department of Human Services
Bureau of Human Service Licensing

June 16, 2021

██████████ ADMINISTRATOR
REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION
2344 PERRYSVILLE AVENUE
PITTSBURGH, PA 15214

RE: REFORMED PRESBYTERIAN HOME
2344 PERRYSVILLE AVENUE
PITTSBURGH, PA, 15214
LICENSE/COC#: 42966

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/05/2021, 04/06/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Larry Mazza

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: REFORMED PRESBYTERIAN HOME **Licen e #:** 42966 **Licen e Expiration Date:** 08/27/2021
Addr e : 2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214
County: ALLEGHENY **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** 4123214139 **Email:** [REDACTED]

Legal Entity

Name: REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION
Address: 2344 PERRYSVILLE AVENUE, PITTSBURGH, PA, 15214
Phone: 4123214139 **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 10/10/1983 **Issued By:** City of Pittsburgh

Staffing Hours

Re ident Support Staff: 0 **Total Daily Staff:** 33 **Waking Staff:** 25

Inspection

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 04/07/2021

Inspection Dates and Department Representative

04/05/2021 - On-Site: [REDACTED]
04/06/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 56 **Residents Served:** 27

Secured Dementia Care Unit

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

Hospice

Current Re ident : 3

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 26
Diagnosed with Mental Illness: 3 **Diagnosed with Intellectual Disability:** 2
Have Mobility Need: 6 **Have Physical Disability:** 0

Inspections / Reviews

04/05/2021 - Full

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*Follow-Up Date: *06/06/2021*

6/7/2021 POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/11/2021*

6/9/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *06/16/2021*

6/16/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from any fossil fuel burning device or appliances. Battery operated carbon monoxide detectors must include with the date of battery installation and replaced at least once annually. The battery operated carbon monoxide detectors located outside of the home's boiler room and kitchen do not include the date the batteries were replaced. The home has numerous fossil fuel burning device.

Plan of Correction

Accept

The carbon monoxide batteries are replaced twice annually by the maintenance staff at daylight savings in the fall and standard time in the spring. Both batteries changes were completed by the maintenance department and noted in the director's off. At the time of inspection, the director was educated that the date must be placed physically on the battery and he placed these dates accordingly. Going forward, at both the battery changes in the fall at daylight savings and the spring at standard time clock adjustments, the batteries will be replaced, the date will be noted on each battery, and the log book will continue to be noted. The Director of Maintenance conducted training of maintenance staff and will maintain all documentation of battery changes. See attached photo.

Completion Date: 04/05/2021

Document Submission

Implemented

20b3 - Written Receipts

1. Requirements

2600.

- 20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

The home provides financial management to numerous residents in the home, including residents #6 and #7; however, the home does not obtain a written receipt from the resident at the time of cash disbursements.

20b3 - Written Receipts (*continued*)**Plan of Correction****Accept**

During withdrawals from the resident accounts, the amount withdrawn was noted on the account ledger and a receipt was given to the resident however not all required information was noted on the receipt and the PCH did not maintain a copy of the receipt. Moving forward, a written receipt will be filled out at the time of each withdrawal and will be kept by the PCH. A copy of the receipt will be given to the resident. Included on the receipt will be the resident's name, the amount of the disbursement, the date, and the time of the disbursement. This will occur at the time of disbursement. Quarterly, the director of finance will audit the resident accounts to ensure process is followed and accounts are accurate. Copies of disbursements will be maintained for 1 year following each disbursement. Please see attached.

Completion Date: 06/09/2021

Document Submission**Implemented**

42x - Safeguard

1. Requirements

2600.

42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

Some time in the middle March 2021, resident #5 notified the home, on numerous occasions, that another resident was wandering into ■■■ bedroom through the shared jack and jill bathroom and removing items from resident #5's bedroom. However, the issue was not resolved until the first week of April 2021. Between the time it was reported and resolved, numerous items were missing from the resident's bedroom, including clothes and perfume.

42x - Safeguard (continued)

Plan of Correction**Directed**

On January 28, 2021, resident #5 informed the PCHA during a virtual visit with the ombudsman that ■■■ was wanted a lock on ■■■ bathroom door to enable ■■■ to lock the door from the bedroom side, preventing the resident in the attached room from entering resident #5's bedroom. A slide lock was installed on January 29, 2021 by the PCHA. Resident #5 was shown how to use the lock and return demonstrated the ability. At this time, resident #5 reported items missing to the PCHA. PCHA was able to find each item resident #5 reported missing in their bedroom located within an extensive amount of clutter and disorganization. Resident #5 has not complained to the PCHA since January 29, 2021 regarding the lock on the bathroom door or reported any additional missing items. Lock will be maintained in working order and will be replaced, if needed. All residents asked if they would like a lock on adjoining bathrooms and have declined. All new admissions will be asked if they would like to have locks placed on all adjoining bathrooms and they will be place upon request.

On 6/7/2021, resident #5 was informed by the PHCA that the home is able to maintain any personal items in the locked safe in the business office that ■■■ would like to safeguard from theft, as well as maintain any money in the member's account in the business office. At this time, resident #5 does not wish to deposit any items in the business safe. Resident made aware that at anytime ■■■ wishes to deposit money or personal items, to inform the PCHA and they will assist ■■■ with making deposit.

DIRECTED: Within 7 days of receipt of the plan of correction: All resident's shall be educated on the home's system to safeguard property. LM 6/9/21

Completion Date: 06/08/2021

Document Submission**Implemented**

All current residents were educated on the availability of placing items into the resident safe and availability of locks being placed on their doors, if requested. All residents expressed understanding. Please see attached education form.

51 - Criminal Background Check

1. Requirements

2600.

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

Description of Violation

Staff person B was hired on ■■■; however, a Pennsylvania criminal background check was not completed until ■■■.

51 - Criminal Background Check (*continued*)**Plan of Correction****Directed**

Staff person B was hired on [REDACTED] as part of the Life Enrichment department and worked in that department until [REDACTED], when [REDACTED] transitioned to the Personal Care department as a resident care aide. At this time, the human resource department did not verify the criminal background check was complete. On [REDACTED], immediately upon notification that the background check documentation was not correctly documented, a criminal background check was completed and was satisfactory, without criminal conduct. To prevent this from occurring again, the human resource department will conduct an additional criminal background check on all employees prior to transferring to the personal care department, as part of the application process. The PCHA will receive and review the results of the background check prior to offering any position within the personal care department to internal transfers.

DIRECTED: Within 7 days of receipt of the plan of correction: A designated staff person shall review all current staff person's records to ensure each staff person has a Pennsylvania criminal background check completed. Copies of criminal background checks shall be kept in each staff person's record. LM 6/9/21

Completion Date: 06/09/2021

Document Submission**Implemented**

All current staff person's records were reviewed by human resources and PCHA. All staff person have completed criminal background checks completed and a copy will be maintained in their HR files.

65a - FS Orientation 1st Day

1. Requirements

2600.

- 65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
 2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
 3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
 4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
 5. The location and use of fire extinguishers.
 6. Smoke detectors and fire alarms.
 7. Telephone use and notification of emergency services.

65a - FS Orientation 1st Day (continued)

Description of Violation

Staff person A, whose first day of work was [REDACTED] did not receive orientation in general fire safety and emergency preparedness, to include the following topics:

- Evacuation procedures
- Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable
- The designated meeting place outside the building or within the fire-safe area in the event of an actual fire
- Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable
- The location and use of fire extinguishers
- Smoke detectors and fire alarms
- Telephone use and notification of emergency services

REPEAT VIOLATION: 2/7/2019

Plan of Correction**Directed**

During the inspection, the staff person A's human resource file was pulled, reviewed by the licensing agent, and [REDACTED] initial education was not part of [REDACTED] active file. At a later time, the staff member's archived file was reviewed by the PCHA and the initial trainings [REDACTED] received upon hire was located and includes the required trainings. All newly hired employees received these topics upon hire. To better document this and to have the documents ready for review by the licensing agency, all initial trainings will remain in the employees active file at all times. Additionally, on each employees first day of work in the personal care department, additional review of all requirements in 2600.65a will be completed by the PCHA or designee. Please see attached training for employee A and first day training list.

DIRECTED: Within 7 days of receipt of the plan of correction: A designated staff person shall review all current staff person's records to ensure each staff person has received training on all topics specified in 2600.65a. Documentation of the education shall be kept in each staff person's record. LM 6/9/21

Completion Date: 06/09/2021

Document Submission**Implemented**

All current staff person's files were reviewed by human resources and PCHA. All staff persons received the training topics specified in 2600.65a. Documentation of the education will be kept in each staff person's HR record.

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/5/21, multiple feces stains were present in the resident lounge bathroom toilet.

On 4/6/21, multiple feces stains were present in resident #1's toilet.

85a - Sanitary Conditions *(continued)***Plan of Correction****Accept**

Feces marks were noted under the water in the toilet bowls of both the resident lounge and resident #1's toilet, as advised by the licensing agent. Upon notification, the PCHA immediately cleaned both toilet bowls. To maintain sanitary conditions, a full-time housekeeping position has been added to the personal care department. This position has been filled and the staff person has been instructed to inspect the toilets daily to ensure sanitary conditions are maintained.

Completion Date: 04/21/2021

Document Submission**Implemented**

90b - Staff Communication

1. Requirements

2600.

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system or method of communication that enables staff persons to immediately contact other staff persons for assistance in an emergency. On 4/5/21 and 4/6/21, the home served 26 residents.

Plan of Correction**Accept**

Although the home was equipped with an emergency pendant alert system to alert staff of emergencies, which each resident wears on a lanyard, the home did not have a verbal means of communication between staff members. On 4/6/2021, the PCHA purchased two-way, handheld radios for use by staff. Staff was trained on the use of the radios and began use on 4/7/2021.

Completion Date: 04/07/2021

Document Submission**Implemented**

91 - Telephone Numbers

1. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

91 - Telephone Numbers *(continued)***Description of Violation**

On 4/5/21, there were no telephone numbers, to include the nearest hospital and police department, posted on or near the telephone in the activities room.

On 4/6/21, there were no telephone numbers, to include the nearest hospital and police department, posted on or near the telephone in resident #2's bedroom.

REPEAT VIOLATION: 2/7/2019

Plan of Correction**Accept**

The phone in the activity room was removed prior to the inspection by the maintenance staff at the direction of the PCHA during a painting project. This included the removal of the emergency numbers which were posted by the telephone. The phone was erroneously reinstalled in the activity department upon completion of the painting project. Upon notification by the licensing agent that the emergency numbers were not posted at this phone, the Director of Maintenance removed the phone from the activity room and advised the maintenance staff that the phone was not to be returned.

In resident #2's bedroom, the licensing agent notified the PCHA that the emergency numbers were not placed by the resident's phone. The PCHA immediately went to the resident's room and found the emergency numbers posting on the floor behind the resident's nightstand and reaffixed the posting near the resident's phone.

The PCHA or designee will audit the phone postings weekly x 1 month, then every other week x 2 months, then monthly x 6 months to ensure emergency telephone numbers are posted at each phone. Any missing or damaged postings will be replaced immediately. Postings to include numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline. See attached audit form which will be used to ensure audit is completed and the postings to be placed by each phone.

Completion Date: 06/09/2021

Document Submission**Implemented**

95 - Furniture and Equipment

1. Requirements

2600.

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

Description of Violation

On 4/6/21, the pipe under resident #1's bathroom sink was leaking.

95 - Furniture and Equipment (*continued*)**Plan of Correction****Directed**

Maintenance was notified immediately of leaking pipe under resident #1's bathroom sink and the pipe was replaced. This corrected the leak under the sink. Maintenance will be notified immediately of all leaks and repairs will be made immediately. (DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons shall be educated on the home's procedures for reporting furniture and equipment that needs repaired or replaced. Documentation of the education shall be kept. LM 6/9/21) PCHA will conduct weekly rounds in resident rooms weekly x 1 month then monthly x 5 months to ensure resident rooms are in good repair, clean and free of hazards. Maintenance will be notified immediately of any concerns or repair needs. See attached audit form.

Completion Date: 06/09/2021

Document Submission**Implemented**

All staff was educated on the home's procedures for reporting furniture and equipment that needs repaired or replaced. Please see attached staff signature sheet signed at education.

101j7 - Lighting/Operable Lamp

1. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 4/6/21, resident #1 did not have an operable lamp or other source of lighting that can be turned on/off at bedside.

On 4/6/21, resident #3's bedside lamp was approximately 4 feet from the resident's bedside and could not be turned on/off at bedside.

Plan of Correction**Accept**

Prior to 4/6/2021 staff assisted resident #1 with rearranging ■■■ room. While doing this, staff moved resident's bedside lamp to the opposite side of the room and did not place another lamp within resident's reach at the bedside. Upon being notified by the licensing agent, the PCHA immediately replaced the lamp by the bedside within reach of the resident. Resident and personal care staff educated that this lamp must remain at bedside within reach of the resident while in bed.

On 4/6/2021, PCHA was informed by the licensing agent that the light at the bedside of resident #3 was too far from the bed. Immediately another lamp was moved beside resident's bed and is in reach of the resident from the bedside.

To prevent this from happening again, an audit of 10 bedside lamps will be completed once monthly to ensure lamps are present, within reach of the resident at bedside, and operational. This audit will be completed by the PCHA or designee. Please see attached audit.

Completion Date: 06/01/2021

101j7 - Lighting/Operable Lamp *(continued)*

Document Submission

Implemented

123b - Emergency Procedures Posted

1. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 4/5/21, the home's emergency preparedness plan and the municipality's emergency preparedness plan were behind the receptionist's desk and not posted in a public and conspicuous place in the home.

Plan of Correction

Accept

The emergency preparedness plan and the municipality's emergency plan were in a binder behind the reception desk. Upon being advised by the licensing agent that these items were not posted in a public and conspicuous place, a copy was immediately made of both items by the PCHA and posted on the bulletin board in the common area in personal care. A copy has also been placed in the main lobby on the first floor and a sign has been posted at the reception desk noting the posting in the main lobby. These items will remain posted at all times and replaced when updates are made. PCHA will audit these postings monthly. Please see picture of posted items.

Completion Date: 06/09/2021

Document Submission

Implemented

141b1 - Annual Medical Evaluation

1. 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, dated 4/17/20, does not include an assessment of the resident's ability to self-administer medications, the name of the medical professional who completed the medical evaluation or the medical professional's license number. These sections of the form are blank.

141b1 - Annual Medical Evaluation (*continued*)**Plan of Correction****Accept**

Resident's medical provider omitted marking the section of the DME which states the manner in which resident #1 is able to administer medication. Also, at the bottom of the form, the medical professional also omitted printing name and license number on the form. Upon notification from the licensing agent of these omissions, the PCHA immediately notified the provider of the omissions and the provider asked for the form to be sent via fax to their office for correction. The form was sent and the provider filled in the omitted sections and returned the form to the PCHA.

To prevent these omissions from occurring again, the PCHA will review all forms received by the residents' providers upon return from their annual appointments. PCHA will ensure all sections are completed before placing DME in the resident record. Provider will be notified of any omitted section and asked to correct and resend form to PCHA for review and confirmation of completeness prior to being placed into the resident record. PCHA will perform monthly audits of all DME and RASPs to ensure they are filled in completely by the resident's provider. Any missing information will be corrected immediately.

Completion Date: 06/09/2021

Document Submission**Implemented**

162c - Menus Posted

1. 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 4/5/21, the menus posted in the home were dated 3/21/21 through 3/27/21 and 3/28/21 through 4/3/21.

Plan of Correction**Accept**

The calendar containing the resident's meals for 7 days was given to the activity director by the dietary director and the calendar was not posted on the resident bulletin board by the activity director, as expected. The activity director and the dietary director were both educated by the PCHA that 2 weeks (14 days) of menus are to be posted at all times. The dietary director or designee will submit the menus to the activity director or designee weekly to replace the expiring menu. This will occur no later than the Friday prior to the current menu expiring. Upon receipt of this menu, on the Sunday morning following the expiration of the current menu, the 2nd week menu will be placed as the current menu and the new menu received by the activity director will be placed in the second week's slot. The activity director or designee will complete this process weekly. The PCHA will also receive copies of the menus and the PCHA or designee will ensure this is completed weekly and will complete the posting in absence of the activity director.

Completion Date: 04/07/2021

Document Submission**Implemented**

171b5 - First Aid Kit

1. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 4/5/21, the first aid kit on the home's bus did not include a thermometer, eye coverings, a breathing shield, tweezers or gloves.

On 4/5/21, the first aid kit in the home's van did not include eye coverings, a breathing shield, thermometer, tweezers or antiseptic.

Plan of Correction

Accept

The van and the bus did not have the required items in their first aid kits. Upon notification from the licensing agent, the PCHA purchased 2 containers for the first aid kits. The kits were each stocked with nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, a thermometer, adhesive tape, scissors, a breathing shield, eye coverings, and tweezers. One kit was placed onto the bus and one onto the van, and the old kits were removed. The vehicle drivers were educated as to the contents of these kits and a content list was placed onto the lids of each container. The drivers were also educated to notify the PCHA or maintenance director each time these kits are used. When notified, the PCHA or maintenance director will inspect the kits and ensure all required items are present. Also, quarterly inspections of the vehicles will occur which is to include verification that each required item is present in each first aid kit. See attached photos.

Completion Date: 04/07/2021

Document Submission

Implemented

171c - Home's Vehicle Documents

1. Requirements

2600.

171.c. The home shall maintain current copies of the following documentation for each of the home's vehicles used to transport residents:

1. Vehicle registration.

Description of Violation

The home uses a bus and a van to transport residents; however, the registration for both of these vehicles expired on 11/30/20.

Plan of Correction

Accept

During the transition between maintenance directors, the registrations for both the van and the bus was not renewed. Upon notification by the licensing agent that both registrations were expired, the PCHA immediately renewed both registrations and placed them into the vehicle. The registration is valid for 2 years and will expire on March 31, 2023. The maintenance director or designee will complete a vehicle check list each quarter which will include verification of the valid registration date. When the registration is due to expire, the maintenance director will renew the registration within the allowable timeframe. See attached Vehicle Quarterly Check List

Completion Date: 04/05/2021

171c - Home's Vehicle Documents (*continued*)

Document Submission

Implemented

184a - Labeling OTC/CAM

1. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #3 is prescribed Novolog Flex Pen Solution 100 units/ml- Inject 3 units subcutaneously 2 times daily for diabetes, as well as sliding scale coverage 3 times a day; however, the pharmacy label only includes instructions for sliding scale administration.

Resident #4 is prescribed Triamcinolone Acetonide Cream 0.1%-Apply to rash affected area topically every 12 hours as needed; however, there is no pharmacy label present on the medication.

Plan of Correction

Accept

Resident #3's insulin was labeled with the sliding scale only but was used for both the sliding scale as well as the twice daily scheduled doses of insulin. The container was not marked by the pharmacy for both orders and the PC staff did not match the pharmacy label with the order as written in the MAR. PCHA notified the pharmacy that the instructions for both the sliding scale and the scheduled doses of insulin must be printed on the bottle of insulin in order to comply with this requirement. The pharmacy will include both orders on the bottle and on all medications that are used as both scheduled and PRN. PC med tech staff were educated that all medications must be verified to match the orders from the physician as written in the MAR upon delivery of the medications.

Resident #4 was ordered Triamcinolone cream and the medication came delivered from the pharmacy in a box with the pharmacy label attached. This tube of cream became separated from the box with the pharmacy label on it. Staff was educated to maintain medication in the original box with the label on it. Also, if the box becomes damaged and can no longer serve to house the medication, staff has been informed to label the medication tube to comply with this requirement.

PC med tech staff to complete audit of all resident medications weekly to ensure all medication is present and correctly labeled per the physician order, and any expiring medication will be reordered and replaced.

PCHA will audit med carts monthly to ensure pc med tech audits are completed correctly and verify medication is present, correctly labeled and unexpired. Please see attached audit forms.

DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated the original container for prescription medications must be labeled with an accurate pharmacy label in accordance with prescribers' orders. Documentation of the education shall be kept. LM 6/9/21

Completion Date: 06/09/2021

Document Submission

Implemented

185a - Implement Storage Procedures

1. 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 blood sugar readings were incorrectly documented on the resident's April 2021 medication administration record (MAR) on the following dates and times:

- On 4/1/21 at 6:14 am, the resident's blood sugar was 142; however, a blood sugar reading of 145 was documented on the resident's April 2021 MAR.
- On 4/4/21 at 10:56 am, the resident's blood sugar was 208; however, a blood sugar reading of 203 was documented on the resident's April 2021 MAR.

Plan of Correction

Accept

Each med tech was educated on the importance of accurate blood glucose monitoring and the possible adverse effects of incorrect documentation. Each med tech also educated on proper technique in recording blood sugar results and instructed to review the blood sugar reading at the time of documentation in the MAR. Each med tech will be observed during their blood sugar checks once daily x 5 days, then three times a week x 2 months, then weekly x 2 months See attached audit

Completion Date: 06/09/2021

Document Submission

Implemented

187d - Follow Prescriber's Orders

1. Requirements

2600.

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

Description of Violation

Resident #3 is prescribed Novolog flex pen 100/unit ml-Inject 3 units subcutaneously 2 times a day for diabetes-hold if blood sugar is below 100. On 4/6/21 at 6:02 am, the resident's blood sugar was 73; however, the home administered 3 units of insulin.

REPEAT VIOLATON: 2/7/2019

187d - Follow Prescriber's Orders (*continued*)**Plan of Correction****Accept**

Per physician order, resident #3 should not have received insulin when his blood sugar reading was below 100. All insulin and blood sugar monitoring orders were reviewed with all staff, including directions on reading the special instructions in the orders, which include when not to administer insulin and when to notify the PCP of the reading. Accuracy of blood sugar monitoring and insulin administration will be monitored as noted in Plan of Correction for 185b. Each med tech will be observed during their blood sugar checks once daily x 5 days, then three times a week x 2 months, then weekly x 2 months See attached audit

Completion Date: 06/09/2021

Document Submission**Implemented**