pennsylvania
DEPARTMENT OF HUMAN SERVICES

February 18, 2020

Ms. Debra Schuetz
Administrator
UPCM Senior Communities
Forbes Tower, Suite 10055B
200 Lothrop Street
Pittsburgh, Pennsylvania 15213

RE: Seneca Manor
5340 Saltsburg Road
Verona, Pennsylvania 15147
License #444990

Dear Ms. Schuetz:

As a result of the Department's Bureau of Human Services Licensing annual inspection on April 25, 2019 and May 1, 2019, of the above facility, the violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2800 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

RECEIVED
10/10/19
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *SENECA MANOR*
License Number: *444990*
Address: *5340 SALTSBURG ROAD, VERONA, PA 15147*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: *Deb Schuetz* **Phone:** *4127986000* **Email:** *GRANTD@UPMC EDU*

Legal Entity

Name: *UPMC SENIOR COMMUNITIES*
Address: *200 LOTHROP STREET, PITTSBURGH, PA, 15213*

Certificate(s) of Occupancy

Type: *I-2* **Date:** *04/14/2010* **Issued By:** *Municipality of Penn Hills*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *105* **Waking Staff:** *79*

Inspection

Type: *Full* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Renewal,Complaint,Incident*

Inspection Dates and Department Representative

04/25/2019 - On-Site: Joe Eveges, Karen Georgeoulis , Courtney Barry

05/01/2019 - On-Site: Joe Eveges, Karen Georgeoulis, Courtney Barry

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *72*

Special Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *70*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *33*
Have Physical Disability: *0*

92 Windows/screens

Requirements

2800.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 4/25/19, the window screen frame was bent, creating approximately a 1 inch gap along the length of the window in the emergency exit stairwell by room #312.

On 4/25/19, there was no screen in the window in the stairwell by room #322

On 4/25/19, there were no screens in the 2 right side windows in the private dining room.

On 4/25/19, the window screen was torn leaving a hole approximately ½ inch in diameter and the window frame was bent, creating approximately a ½ inch gap along the length of the window, in the window in the emergency exit stairwell by room 212.

Repeat Violation: 05/14/2018

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

All screens in the building were checked immediately. Any screen that was found to be bent or in disrepair were replaced or repaired.

Within 30 days of receipt of the plan of correction: All staff shall be trained to immediately report any damaged windows or screens to the administrator. Documentation of training shall be kept.

weekly SE 2/14/20

Maintenance will check screens on a quarterly basis to ensure they are in good repair.

Any deficiencies discovered shall immediately be reported to the administrator and be repaired or replaced. Documentation of checks shall be kept. SE 2/14/20

Legal Entity Representative

Signature

Debra Schuetz Admin. 10·10·19

Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

103f Fridge/Freezer Temps

Requirements

2800.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/25/19, the temperature in the small white refrigerator in the 1st floor medication room was 44 degrees Fahrenheit.

On 4/25/19, the temperature in the Thermo-Scientific refrigerator in 1st floor medication room was 41 degrees Fahrenheit.

Repeat Violation: 05/14/2018

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Tempature logs are kept for 1st, 2nd + 3rd Floor med room refridgerators.

Responsibility of 11-7 nurse to date, initial, + record temperature daily. Any refrigerator temperatures above 40°Fahrenheit and any freezer temperatures above 0°Fahrenheit shall immediately be reported to the administrator and the refrigerator and/or freezer shall immediately be repaired or replaced. Documentation of checks shall be kept.

CC. Attached log - a new log has been initiated to clarify the 2800 regulation and how to resolve if there is an issue. SE 2/14/20

Legal Entity Representative

Signature

Debra Schuetz Admin. 10.10.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

121a Unobstructed egress

Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

On 4/25/19, the emergency exit doors on the far right and far left of the main dining area could not be fully opened due to a build up of salt and rust on the bottom thresholds.

On 4/25/19, at approximately 12:30 p.m., residents were seating and eating lunch at 2 tables pushed together in left corner of the dining area. These tables blocked the 2 emergency exits located in the left corner of the dining area.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

-On 4.25.19 that emergency door was replaced in it's entirety while the surveyors were here. Maintenance will open the doors monthly to ensure they open freely.
-The dining room has been rearranged and space made to ensure clear egress from the dining room.
Any other residents who require assistance during meals will be seated elsewhere.

*See Picture attached

Immediately, then at least weekly, a designated staff person shall inspect all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed. Documentation of inspections shall be kept.

SE 2/14/20

Legal Entity Representative

Signature

Debra Schuetz Admin 10.10.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

SENECA MANOR 444990

132h Designated meeting place

Requirements

2800.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill conducted on 3/27/19 at 6:33 a.m., the following residents remained in their bedrooms and failed to evacuate to a designated meeting place away from the building or within the fire-safe area: resident #1, resident #2 and resident #3.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.132 (h.) Immediately and going forward all residents will be removed from their rooms during a fire drill. They will be moved to the center of the hallway which has been deemed a fire safe area by the Fire Professional. The residents residing in the affected area will be transported to a fire safe area away from the "fire". In-Services were held for all residents regarding the fire drill Jan 22, 23, 24th of 2020 to remind them of their responsibilities. The staff has been reeducated in April of 2019 and again on Jan. 8, 2020.

Legal Entity Representative

Signature — Debra Schultz — Printed Name and Title — 2/14/20 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☒ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☒ Partially Implemented - Inadequate Progress
- ☒ Not Implemented

161d Special dietary needs

Requirements

2800.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #4's annual medical evaluation, dated 10/3/18, indicates the resident is prescribed a mechanical soft diet. However, on 4/25/19, the resident was served pork chops, roasted seasoned potatoes and cauliflower for lunch.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately the Food Service Director educated all staff on special diets. The dietary board was updated and it was stressed to staff to utilize the board daily.

The Food Service Director will randomly check plates before they leave the kitchen to ensure correct diets are being served at least weekly. Documentation shall be kept.

SE 2/14/20

Legal Entity Representative

Signature

Debra Schuetz Admn. 10.10.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

183d Current medications

Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 10/4/18, resident #5 was prescribed Lidocaine Oint 5% - apply topically to affected area once daily for 30 days.
On 5/1/19, this medication was still in the home.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #5 Lidocaine Oint 5% was removed and destroyed immediately.
Nurse + medication technician re-education was reviewed at the monthly nurses meeting on September 24th. The education and sign-in sheets are attached.
The DRC or designee will do random monthly cart audits to ensure medications are currently prescribed and physicians orders are followed.

Audits shall include an audit of all medication in the residence, resident MARs and prescriber's orders to ensure only current prescription, OTC sample and CAM for individuals living in the home are present, documented on the resident MAR and administered. Any discontinued medication discovered shall not be administered, immediately disposed of in accordance with §2800.183.f and the resident MAR shall be updated to indicate it has been discontinued. Documentation of audits shall be kept. SE 2/14/20

Legal Entity Representative

Signature | Debra Schuetz Admin | 10.10.19
Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

183e Storing Medications

Requirements

2800.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/1/19, there was a Humalog 100/ml injector for resident #6, in the 1st floor medication cart. The manufacturer's instructions indicate this medication expires 28 days after opening. The injector was opened on 3/25/19, which exceeds 28 days.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Expiration dates are applied to every injection pen with the date open sticker. A list of expiration instructions for all insulins are hung in every medication room for reference. Nurses and medication technicians were re-educated on application of expiration date stickers.

The DRC or designee will do random monthly cart audits to ensure all medications are used within the manufacturer's instructions. Documentation of audits shall be kept. SE 2/14/20

Legal Entity Representative

Signature

Debra Schuetz Admin. 10.10.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

184a Labeling

Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #6 is prescribed Loperimide 2mg – take one cap by mouth every 8 hours as needed. However, the pharmacy label indicates – Loperimide 2mg – take one cap by mouth every 2 hours as needed.

Resident #6 is prescribed Acetaminophen 325mg – take two tabs by mouth every 6 hours as needed. However, the pharmacy label indicates – Acetaminophen 325mg – take two tabs by mouth every 4 hours as needed.

Repeat Violation: 05/14/2018

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #6 labels were corrected. See attached document
All orders are approved by an LPN or medication technician and then red-lined for a second approval by an LPN/RN.
Re-education will be done to ensure all orders and labels are thoroughly reviewed as they are prescribed.
The DRC or designee will conduct random monthly chart audits to ensure all medications are properly labeled.

The audit shall include an audit of all prescription medications to ensure they are stored in their original container and labeled with a pharmacy label in accordance with 2800.184a. The pharmacy label and the MAR shall be compared to the prescriber's order. Any discrepancies discovered shall be verified with the prescriber and immediately corrected. Documentation of audits shall be kept. SE 2/14/20

Legal Entity Representative

Signature | Debra Schuetz Admin. 10.10.19 (Printed Name and Title / Date)

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

185a Storage procedures

Requirements

2800.
185.a. The residence 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

The home's Management of Controlled Drugs policy, section 7, indicates "Destroy/dispose of controlled drugs according to federal and state regulations. Destruction must be done by the DRC or designee and another licensed nurse/medical technician." On multiple occasions direct care staff B, direct care staff C and direct care staff D failed to properly dispose of various narcotic medications per the home's policy and falsified documentation of these disposals to include the following resident's medications:
*On 1/31/19 direct care staff B and direct care staff C documented they wasted 30 tabs of Oxycodone 5mg ½ tablets for resident #7
*On 1/30/19 direct care staff B and direct care staff C documented they wasted 30 tabs of Oxycodone 5mg tablets for resident #8
*On 1/24/19 direct care staff B and direct care staff C documented they wasted 30 tabs of Oxycodone 5mg tablets for resident #9
*On 2/2/19 direct care staff B and direct care staff D documented they wasted 30 tabs of Oxycodone 5mg tablets for resident #6
*On 2/2/19 direct care staff B and direct care staff D documented they wasted 27 tabs of Oxycodone 5mg tablets for resident #6
*On 2/2/19 direct care staff B and direct care staff Documented they wasted 27 tabs of Lorazepam 0.5mg tablets for resident #6

Direct care staff B, direct care staff C and direct care staff D confessed to falsifying documentation attesting to proper disposal of medications. Direct care staff B confessed to stealing narcotics from residents for his/her personal use.

The home's Management of Controlled Drugs policy, section 4.1, indicates "After pouring the medication for administration, log out the drug on the controlled drug inventory page. Include date, time, number/amount of drug, and signature". However, there is no controlled drug inventory page in resident #10's record for the following dates: 2/8/19 through 2/14/19 and 2/24/19 through 3/11/19 for the resident's prescribed Oxycodone 5mg.

On 5/1/19, resident #6's glucometer was not calibrated to the correct date and time.

Resident #11 is prescribed Nitroglycerin 0.4mg – place one tablet under tongue every 5 minutes for three doses as needed for chest pain. However, this medication was not available in the home on 5/1/19.

Resident #11 is prescribed Triamcinolon cream 0.1% - apply topically to ischial rash as needed. However, this medication was not available in the home on 5/1/19.

Repeat Violation: 05/14/2018

185a Storage procedures *(continued)*

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately following the diversion incident a new Procedure was devised and implemented for receiving, and wasting of narcotics.
There are now 2 places where the narcotics are documented. The first is on the Reconciliation/Care sheet from the Pharmacy. The next is on the Master Narcotic log that is kept in a separate binder. DRC showed waste all narcotics.
An education was done with all med passers in March. Reminders are given at monthly nursing meetings about the importance of following Protocal.
Glucometers are checked weekly using the Audit log by Med Tech's. Regarding Res #11. The missing PRN medications were ordered immediately and received from the pharmacy for availability to the Res. 2/14/20 SE
Staff re-educated regarding timely ordering.
DRC or designee to do monthly cart audits

Audits shall consist of an audit of all physician orders, medications in the home and resident MARs to ensure all prescribed medications are available in the home for administration, to include PRN medications. Documentation of audits shall be kept.

Legal Entity Representative

Signature

Debra Schuetz Admin. 10.10.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

187a Medication record

Requirements

2800.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #6 is prescribed blood glucose checks 3 times per day. The following blood glucose readings documented on her April 2019 MAR do not match the readings on her glucometer:

Date/Time	MAR	Glucometer
4/7/19, 12:04 p.m.	157	153
4/8/19, 5:41 a.m.	226	266
4/9/19, 6:41 a.m.	186	185
4/10/19, 11:35 a.m.	289	285
4/10/19, 5:20 p.m.	274	145
4/16/19, 8:43 a.m.	226	236

Resident #12 is prescribed blood glucose checks 4 times per day. The following blood glucose readings documented on his April 2019 MAR do not match the readings on his glucometer:

Date/Time	MAR	Glucometer
4/3/19, 9:01 p.m.	340	351
4/5/19, 9:31 p.m.	243	195
4/8/19, 9:12 p.m.	295	207

Description of Violation *(continued)*

Resident #13 is prescribed blood glucose checks 4 times per day. The following blood glucose readings documented on her April 2019 MAR do not match the readings on her glucometer:

Date/Time	MAR	Glucometer
4/24/19, 4:53 p.m.	142	147
4/25/19, 8:32 p.m.	120	128
4/26/19, 6:43 a.m.	142	149
4/29/19, 3:46 p.m.	147	167
4/29/19, 9:19 a.m.	214	204

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Each residents glucometer and supplies are stored in separate containers that are in the assigned medication carts to prevent transcription errors when documenting in the MAR.

All trained staff who perform blood glucose checks were re-educated on safe glucometer use and documentation: this education was documented for verification of completion. See attached in service.

The DRC or designee will conduct random monthly cart audits and MAR audits to ensure compliance with glucometer use and documentation of blood sugar readings.

Legal Entity Representative

Immediately, then once per week for 2 months and monthly thereafter, the administrator or designated staff person qualified to administer medications shall observe each staff person responsible for diabetic care perform blood glucose checks to ensure blood glucose readings are accurately documented on the resident MAR and Insulin, to include sliding scale, is administered according to the directions of the prescriber and properly documented on the resident MAR. Documentation of the observations shall be kept and reviewed at the next Quality Management Meeting.

Signature | Debra Schuetz Admin. 10.10.19 Printed Name and Title | SE 2/14/20 Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

187d Follow prescriber's orders

Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 is prescribed Humalog injection 100units/ml – blood glucose monitor three times daily with subcutaneous coverage before meals if blood sugar is 70-140=0 units, 141-180=1 unit, 181-220=2 units, 221-260=3 units, 261-300=4 units, 301-340=5 units, 340=6 units and call MD.

On 4/8/19 at 5:41 a.m., resident #6's blood sugar reading was 266 and the resident was administered 3 units of Humalog. However, according to the prescriber's orders, 4 units of Humalog should have been administered.

Resident #12 is prescribed Blood glucose checks 4 times per day and Humalog insulin 100mg/ml per sliding scale as follows - 70-140=2 units, 141-180=4 units, 181-220=6 units, 221- 260=8 units, 261 – 300=10 units, 301 – 340=12 units, 341 and above=14 units and call MD.

On 4/3/19 at 8:59 p.m., resident #12's blood sugar reading was 351 and the resident was administered 14 units of Humalog; however, there is no record the home contacted the resident's physician.

On 4/5/19 at 9:27 p.m., resident #12's blood sugar reading was 195 and the resident was administered 8 units of Humalog. However, according to the prescriber's orders, 6 units of Humalog should have been administered.

187d Follow prescriber's orders *(continued)*

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Each residents glucometer and supplies are stored in separate containers that are in the assigned medication carts. A copy of the sliding scale orders are taped inside the containers for reference to ensure the appropriate amount of insulin is administered per the physicians orders. The charge nurse/ nurse signing off orders will be sure that the sliding scale orders are updated as ordered.

The DRC or designee will conduct random monthly audits to ensure the directions of the prescriber are being followed.

Immediately, then once per week for 2 months and monthly thereafter, the administrator or designated staff person qualified to administer medications shall observe each staff person responsible for diabetic care perform blood glucose checks to ensure blood glucose readings are accurately documented on the resident MAR and Insulin, to include sliding scale, is administered according to the directions of the prescriber and properly documented on the resident MAR. Documentation of the observations shall be kept and reviewed at the next Quality Management Meeting.

SE 2/14/20

Legal Entity Representative

Signature

Debra Schuetz Admin. 10.10.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 2/14/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 2/14/20 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented