pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: paulahahn@fritzingertown.com
MAILING DATE: March 2, 2020

Ms. Paula Sagan-Hahn
Executive Director
Lakewood Senior Living-Drums LLC
159 South Old Turnpike Road
Drums, Pennsylvania 18222

RE: Fritzingertown Senior Living Community
License #: 201660

Dear Ms. Sagan-Hahn:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on November 26, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Anne Graziano
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *FRITZINGERTOWN SENIOR LIVING COMMUNITY*
License Number: *20166*
Address: *159 SOUTH OLD TURNPIKE ROAD,, DRUMS, PA 18222*
County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

Name: *Paula Hahn* **Phone:** *5707884178* **Email:** *PAULAHAHN@FRITZINGERTOWN.COM*

Legal Entity

Name: *LAKEWOOD SENIOR LIVING-DRUMS LLC*
Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA, 18222*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/23/2003* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *160* **Waking Staff:** *120*

Inspection

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

Inspection Dates and Department Representative

11/26/2019 - On-Site: Ryan Yankowy, Amy Deluca

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *164* **Residents Served:** *119*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *n/a* **Capacity:** *60* **Residents Served:** *39*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *119*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *41*
Have Physical Disability: *8*

17 - Record Confidentiality

Regulations

2600.

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

Description of Violation

The resident privacy coding document was attached to the licensing inspection summary dated 7/17/19 that was posted in the homes lobby. The privacy coding document exposes confidential information of the residents.

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.)

See attachment relating to this regulation.

Legal Entity Representative

[signature] Paula Sagan-Halloran - Executive Director 01/15/20

Signature | Printed Name and Title | Date

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

The above plan of correction is approved as of 2-11-2020 (Date)

Plan of correction implementation status as of 2-11-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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

Regulation -2600.17 -Resident records shall be kept confidential and not accessible.

Why it Happened?

Although the Licensing inspection summary was placed in binder at reception desk, and posted as required by BHSL, the privacy coding inadvertently remained attached to the inspection summary.

What was done immediately to fix the problem?

Privacy coding was immediately removed from document by Executive Director (11/26/19).

What will be done to prevent this from happening again?

As licensing inspection summaries are received, the Executive Director will review to ensure privacy coding is removed.

2-11-2020 ag

Paula Sagan-Hahn Executive Director 01/15/2020

81b - Resident Personal Equipment

Regulations

2600.

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

Description of Violation

The bed rail attached to the bed closest to the door in resident room #23 did not have a cover over it, posing a possible limb entrapment.

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.)

See attachment relating to this regulation

Legal Entity Representative

[signature] Paula Sagan Walker, Executive Director 01/15/2020

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Regulation -2600.81. b Wheelchairs, walkers and other apparatus used by residents must be clean, in good repair and free of hazards.

Why it Happened?

The cover for a bedside enabler was removed for laundering shortly before being discovered by BHSL inspector. Resident was not in bed at time.

What was done immediately to fix the problem?

A fresh, unsoiled enabler cover was replaced immediately by Resident Care Coordinator.

Allison Kline, LPN. (11/26/2019)

What will be done to prevent this from happening again?

All direct care staff and housekeeping aides were re-in serviced (11/26 and 11/27/2019) by Director of Nursing that no enabler cover is to be removed unless replacement is immediately available.

Resident Care Coordinator or Housekeeping Supervisor will monitor daily x1 week and then weekly x one month ,then monthly x 6 months to ensure compliance to this regulation .

Director of Nursing will monitor monthly for compliance.

2-11-2020 ag

Paula Sagan-Hahn RD Executive Director 01/15/2020

89a - Water Pressure

Regulations

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

The bathrooms in resident room #'s 9 and 10 located in the secure dementia unit did not have hot water.

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.)

See attachment relating to this regulation.

Legal Entity Representative

[signature]
Signature

Paula Sagan Haller - Executive Director
Printed Name and Title

01/15/2020
Date

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2600.89.a The home must have hot and cold water under pressure to each bathroom, kitchen and laundry area to accommodate the needs of the residents of the home.

Why it Happened?

Water in resident's powder rooms of memory care unit have an adequate supply of warm running water and soap to safely meet the hygiene and handwashing needs of the residents if unsupervised by staff members.

Water temperatures in resident powder rooms (including room 9 and 10) reach 108 degrees Fahrenheit with 90 seconds of hot water demand.

What was done immediately to fix the problem?

Water temps to these rooms was addressed as temperature is maintained to assure safe water temperature delivery in the event of water use by resident if unsupervised by staff.

Facility has separate showering and bathing suites with adequate water supply. **All** resident showers and baths in memory care unit are with staff supervision to ensure safe water temperature usage.

What will be done to prevent this from happening again?

No changes will be made at this time as our primary goal is maintaining resident safety.

2-11-2020 ag

Paula Sagan-Hakes RN Executive Director 01/15/2020

105g - Lint Removal and Duct Cleaning

Regulations

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

The GE commercial dryer located in the resident laundry area had a handful of lint in the lint trap, posing a possible fire hazard.

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.)

See attachment relating to this regulation

Legal Entity Representative

[signature]
Signature

Paula Sagan Haller Executive Director
Printed Name and Title

01/15/20
Date

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Regulation -2600. 105.g-To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use.

Why it Happened?

This dryer is utilized by residents in independent living. An Independent living resident who used dryer did not remove lint.

What was done immediately to fix the problem?

Lint was immediately removed at time of inspection. (11/26/2019)

What will be done to prevent this from happening again?

Independent living residents were re-educated in the fire risk associated with lint not being removed from dryer following each use. (11/27/2019 and 11/28/2019)

A sign reminding residents stating *"Please remove lint from dryer after each use"* is posted over each dryer. (11/27/2019)

Additionally, housekeeping staff shall regularly check independent living resident's dryers to ensure that residents are removing lint after each use.

2-11-2020 ag

Paula Jagan Hahn ED Executive Director 01/15/20

127a - Portable Space Heaters

Regulations

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

Description of Violation

A DuraFlame portable space heater was located in the willows dining room plugged in. Portable space heaters are prohibited.

Plan of Correction (POC)

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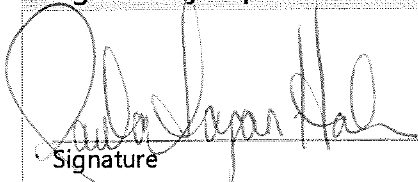
Legal Entity Representative



Signature | Paula Sagan-Holwed Executive Director | Printed Name and Title | 01/15/20 Date

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

Why it Happened?

Space heater (non-functioning at time of inspection) was placed in dining room, at residents' request,

What was done immediately to fix the problem?

Space heater was immediately removed at time of inspection.(11/26/2019)

What will be done to prevent this from happening again?

All staff members were re-in serviced that space heaters are always prohibited. These in services were performed on 11/26/2019,11/27/2019 and 11/28/2019.

2-11-2020 ag

Paula [signature] Executive Director 01/15/2020

132h - Designated Meeting Place

Regulations

2600.
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

Interviews with staff members indicated that during inclement weather the residents do not evacuate to the outside of the building. The residents will congregate by the doors.

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.)

See attachment relating to this regulation

Legal Entity Representative

[signature] Signature

Paula Sagan-Haldeman Exec Director — Printed Name and Title

01/15/20 — Date

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Regulation -2600.132. h. Residents shall evacuate to a designated meeting place away from the building or within fire -safe area during each fire drill.

Why it Happened?

On rare occasions, for resident and staff safety residents had not been completely evacuated into inclement weather conditions during monthly fire drills. Instead they were assembled at the exit inside the building.

What was done immediately to fix the problem?

Meeting held 11/27/2019 with Executive Director, Director of Nursing, Maintenance Director, nursing supervisors to discuss possible alternatives to evacuate to safe areas during inclement weather.

What will be done to prevent this from happening again?

Going forward, residents of personal care will be evacuated to alternate facility building immediately following evacuation, thus limiting resident and staff exposure to weather conditions.

Residents of secured memory care will be evacuated according to facility policy.

Fire drills will be conducted during optimal weather conditions for that season.

2-11-2020 ag

Paula Sagan-Walker RN Executive Director 01/15/20

144b - Policy on Smoking

Regulations

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The home rules in the contract dated 8/22/2019 for resident #1 indicate that smoking is allowed in the 4 designated smoking areas located outdoors at the four corners of the home. The home's current smoking policy is to allow smoking only at 1 location, in the far corner of the side parking lot. The contract for resident #1 did not contain the current smoking policy for 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.)

See attachment relating to this regulation

Legal Entity Representative

[signature] Paula Sagan Haker RN Executive Director 01/15/20

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Regulation -2600.144. b. The home's rules shall specify whether the home is designated as smoking or non-smoking.

Why it Happened?

The facility had no residents who smoked prior to 7/2018.At that time one independent living resident began to smoke outside facility. Designated smoking area was relocated to a safer area nearer to this resident.
Resident contract and facility rules for residents admitted after 7/2018 were not revised to update this change.

What was done immediately to fix the problem?

No immediate resolution was possible to revise past agreements, facility rules.

What will be done to prevent this from happening again?

Smoking policy, resident agreements and facility will be updated by the Executive Director to state the existence and location of ***one*** designated smoking area on facility campus. This will affect all future residents of facility. Expected completion date (01/20/2020)

All present residents and staff will receive written notice from Executive Director to state the existence and location of ***one*** designated smoking area on facility campus. Expected completion date (01/20/2020).

2-11-2020 ag

Paula Pagan-Nalsh RN Executive Director 01/15/2020

184a - Labeling OTC/CAM

Regulations

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #4's levemir insulin pen does not include the staff person's initials who opened the pen.

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.)

See attachment relating to this regulation.

Legal Entity Representative

[signature] Signature

Paula Seeger-Halvorsen - Executive Director — Printed Name and Title

01/15/20 — Date

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Regulation -2600.184. a. The original container for prescription medication shall be labeled with a pharmacy label that includes, the residents name, the name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration and the name and title of the prescriber.

Why it Happened?

Med tech documented the date and time the Levamir pen insulin pen was opened as required but failed to initial at time of this action.

What was done immediately to fix the problem?

Med tech who opened the Levamir pen was identified and she initialed the pen.

What will be done to prevent this from happening again?

All med techs and LPN's were reinserviced in the requirement of this regulation by the Director of Nursing, Linda Palermo.

Resident Care Coordinators Allison Kline, LPN /Tina Light, Lisa McAlarney LPN will audit med carts daily ensure that each Insulin pens /Vials is initialed and dated by person opening these medications.

Contracted pharmacy tech will check med carts monthly.

Director of Nursing, Linda Palermo BSN, RN will audit med carts weekly x 4 to ensure compliance to this regulation.

2-11-2020 ag

Paula Pagan-Haley RN Executive Director 01/15/20

184b - Resident's Meds Labeled

Regulations

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #2's aspirin and Resident #3's cranberry was not labeled with the residents name.

Repeat Violation: 9/12/18

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.)

See attachment relating to this regulation

Legal Entity Representative

[signature] RD

Signature

[signature] Executive Director 01/15/20

Printed Name and Title Date

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☒ Implemented
☐ Not Implemented

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Regulation -2600.184. b. OTC medications and CAM belonging to the resident shall be identified with the resident's name.

Why it Happened?

Over-the Counter medication was delivered to facility by family member. Med tech placed the medications in the resident med cart drawer and failed to write resident name on bottle.

What was done immediately to fix the problem?

Resident name was written on bottles of OTC by Allison Kline, LPN at time of inspection.

What will be done to prevent this from happening again?

All med techs and LPN's were reinserviced in the requirement of this regulation by the Director of Nursing, Linda Palermo.

Resident Care Coordinators Allison Kline, LPN /Tina Light, Lisa McAlarney LPN will audit med carts daily ensure that all OTC/CAM medications are labeled with resident name.

Contracted pharmacy tech will check med carts monthly.

Director of Nursing, Linda Palermo BSN, RN will audit med carts weekly x 4 to ensure compliance to this regulation.

2-11-2020 ag

[signature] RN Executive Director 01/15/20

185a - Implement Storage Procedures

Regulations

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 #5's straight order of ativan and PRN of milk of magnesium was not available at the time of the inspection.

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.)

See attachment relating to this regulation

Legal Entity Representative

[signature] Signature

[handwritten] Printed Name and Title

01/15/20 Date

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Regulation -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.

Why it Happened?

Although order placed with pharmacy three days in advance, resident's pharmacy had not delivered medication as requested.

What was done immediately to fix the problem?

Pharmacy was notified of immediate need for these medication which were delivered later that day 11/26/2019.

What will be done to prevent this from happening again?

All med techs and LPN's were reinserviced in the requirement of this regulation by the Director of Nursing, Linda Palermo.

For medications being delivered from this resident's pharmacy –calls to re-order medications will be made 5 days in advance of supply depletion.

Resident Care Coordinators Allison Kline, LPN /Tina Light, Lisa McAlarney LPN will audit med carts daily to ensure that adequate supply of medications are available at all times.

Contracted pharmacy tech will check med carts monthly.

Director of Nursing, Linda Palermo BSN, RN will audit med carts weekly x 4 to ensure compliance to this regulation.

2-11-2020 ag

Paula Jagan-Naln RN Executive Director 01/15/20

187a - Medication Record

Regulations

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

Description of Violation

The bottle of Resident #5's warafin notes take two 2.5mg tablets on Thursday. The MAR notes take 1 5mg tablet on Thursday.

Repeat Violation: 9/12/18

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.)

See attachment relating to this regulation.

Legal Entity Representative

[signature] Signature

Paula Sogan-Holder RN Executive Director — Printed Name and Title

01/15/20 — Date

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Regulation -2600.184. a. A medication record shall be kept to include the dose for each resident for whom medications are administered.

Why it Happened?

The prescriber's order for this medication was changed several days following the pharmacy's "filling" of this prescription. Order was changed from "Warfarin 1.5 mg daily to Warfarin 1.5 mg daily with the exception of Thursdays,"-resident to receive 2.5 mg on Thursdays. This resident's pharmacy stated they were unable to "send a new Warfarin medication" as the resident prescription plan would not pay for new prescription.

LPN placed an "order change" sticker on med vial. These stickers are provided by pharmacies to alert these administering medications to be aware to view the Medication Administration Record for recent changes to avoid med error.

What was done immediately to fix the problem?

Resident family was notified of need for resident's pharmacy to have new medication filled as per prescriber's order.

What will be done to prevent this from happening again?

All med techs and LPN's were reinserviced in the requirement of this regulation by the Director of Nursing, Linda Palermo.

Resident Care Coordinators Allison Kline ,LPN /Tina Light ,Lisa McAlarney LPN will audit med carts daily to ensure that adequate supply of medications are available at all times.

In the event that resident pharmacy does not fill medication as needed for medication administration, this medication will be ordered from facility pharmacy for prompt delivery of medication to avoid medication error.

Director of Nursing, Linda Palermo BSN, RN will audit med carts weekly x 4 to ensure compliance to this regulation.

2-11-2020 ag

Paula Sagan-Holden Executive Director 01/15/20

233d - Electronic/Magnetic System

Regulations

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The Evergreen courtyard gate's magnetic lock which exits to old turnpike road is not engaging. The gate leads to an unsafe 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.)

See attachment relating to this regulation

Legal Entity Representative

Paula Sagan Hahn RN | Paula Sagan Hahn RN Exec Director | 01/15/2020

Signature | Printed Name and Title | Date

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- [ ] Not Implemented

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Regulation -2600. 233.d- Doors that open onto areas such as parking lots or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Why it Happened?

Magnet device on doors disengaged due to weather related shift of door apparatus.

What was done immediately to fix the problem?

Magnet devices were immediately adjusted by David Stash, Maintenance Director, to ensure proper functioning.

What will be done to prevent this from happening again?

Maintenance staff performing daily a "door check" to ensure compliance to this regulation.

2-11-2020 ag

Paula Sagan Walker Executive Director 01/15/20