Department of Human Services
Bureau of Human Service Licensing

March 25, 2021

[REDACTED] VICE PRESIDENT
DUBOIS CONTINUUM OF CARE COMMUNITY INC
282 SOUTH EIGHTH STREET
DUBOIS, PA 15801

RE: DUBOIS VILLAGE
282 SOUTH EIGHTH STREET
DUBOIS, PA, 15801
LICENSE/COC#: 44867

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/03/2021, 03/04/2021 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: *DUBOIS VILLAGE* **Licen e #**: *44867* **Licen e Expiration Date**: *06/04/2021*
Addre : *282 SOUTH EIGHTH STREET, DUBOIS, PA 15801*
County: *CLEARFIELD* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *8143755483* **Email**: [redacted]

Legal Entity

Name: *DUBOIS CONTINUUM OF CARE COMMUNITY INC*
Address: *282 SOUTH EIGHTH STREET, DUBOIS, PA, 15801*
Phone: *8143755483* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/07/1996* **Issued By**: *Dept of L&I*
Type: *I-2* **Date**: *08/02/2011* **Issued By**: *Bureau Veritas North America Inc*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *03/04/2021*

Inspection Dates and Department Representative

03/03/2021 - On-Site: [redacted]
03/04/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *118* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Willow Lane Memory Support* **Capacity**: *9* **Residents Served**: *7*

Hospice

Current Re ident : *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *44*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *10* **Have Physical Disability**: *1*

Inspections / Reviews

03/03/2021 - Full

Lead In pector: **Follow Up Type:** *POC Submission* **Follow-Up Date:** *03/18/2021*

3/16/2021 POC Submi ion

Lead Reviewer: **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/23/2021*

3/25/2021 - Document Submission

Lead Reviewer: **Follow-Up Type:** *Not Required*

85d - Trash Receptacles

1. **Requirements**

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 3/3/21, there were uncovered trash cans containing trash in the following areas:

- *The 2nd floor common resident bathroom on Laurel*
- *The staff bathroom behind Laurel nurse's station desk*

Plan of Correction **Accept**

The garbage cans identified without lids were immediately replaced with those with lids attached (Photo 1 and Photo 2 attached).
The Administrator performed an audit of other bathrooms and kitchens in facility to ensure compliance (garbage can and bar of soap audit 3/5/21 attached).
Staff was provided re-education on this requirement completed by 3/12/21 (inservice personal care staff and auxiliary staff attached).
A monthly audit will be performed by the Administrator/designee x 3 months then quarterly thereafter to ensure compliance.
The monthly audit will be reviewed at the monthly Quality Assurance meeting to identify any further corrective action needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation Attached

100b - Removal Snow/Obstructions

1. **Requirements**

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 3/3/21 at 10:17 am, an accumulation of snow was covering the sidewalks and cement area outside of the emergency exit from bedroom #[redacted] to the back of the building

On 3/3/21 at 10:25 am, a coating of ice was present on the sidewalks outside the activity room towards the smoking area.

On 3/3/31 at 10:32 am, ice covered an approximate 10' area of the sidewalk next to the fence in the memory care courtyard.

100b - Removal Snow/Obstructions *(continued)*

Plan of Correction **Accept**

Maintenance removed the snow/ice from the three areas identify after the walk thru was complete (Photo 3, photo 4 and photo 5 attached). The Administrator performed an audit of the exits, sidewalks, courtyards and entrances to ensure compliance (Exterior safety audit attached). Staff provided re-education on this requirement by 3/12/21 (see attached inservice records).
n order to ensure compliance a random audit will be completed by the Administrator/designee after inclement weather that creates an obstruction.
The audit results will be reviewed at the monthly Quality Assurance meeting to identify any further corrective action needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation Attached.

102i - Soap Dispenser

1. **Requirements**

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 3/3/21, there were unlabeled, used bars of soap present in the following locations:
- *On the sink in the staff bathroom behind the Laurel unit's nurses station*
- *On the sink and in the shower of the shared bathroom in bedroom #*

Plan of Correction **Accept**

The bar of soap in the staff bathroom was immediately thrown out. There was already a soap dispenser with soup mounted on the wall in this bathroom. Maintenance installed a wall soap dispenser in the shared room # (see attached photo #8). Both residents educated that the dispenser was installed for their hand washing use. Each resident uses bottle body wash for bathing that is labeled with their name.
The Administrator performed an audit of bathrooms throughout the facility to ensure compliance (see attached garbage and bar of soap audit 3/5/21). Staff re-education was completed by 3/12/21 (see attached training record). The Administrator/designee will perform monthly audit x 3 month then quarterly to ensure compliance. The audits will be reviewed at the monthly QA to identify any further corrective action needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation attached.

103e - Left Overs

1. **Requirements**

2600.

103e - Left Overs *(continued)*

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 3/3/21 at 10:38 am, the following undated leftover foods were stored in the dorm sized refrigerator in the secured dementia care unit's (SDCU) kitchen:

- *A chocolate shake in a glass*
- *A cup each of canned pears and mandarin oranges*

Plan of Correction **Accept**

The unlabeled/undated food was immediately thrown away. The Director of Wellness performed an audit of the refrigerators on each unit to ensure compliance (see attached refrigerator/freezer audit).
Staff re-education was provided on this requirement and completed by 3/12/21 (see attached training records).
The Administrator/designee will perform a weekly audit x 4 months then monthly thereafter to ensure compliance.
The audit results will be reviewed at the monthly Quality Assurance meeting to identify if any further corrective action is needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation Attached.

103f Refrigerator/Freezer Temps

1. **Requirements**

2600.

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 3/3/21 at 10:38 am, there was no thermometer present in the freezer of the small dorm-size refrigerator/freezer in SDCU kitchen.

Plan of Correction **Accept**

A thermometer was placed in the SDCU freezer on 3/3/21 (see attached photo 9). The Director of Wellness performed an audit of the other unit refrigerator/freezers to ensure compliance (see attached refrigerator/freezer audit).
Staff re-education was performed on this requirement and completed by 3/12/21 (see attached training records).
The Administrator/designee will perform a weekly audit x 4 months then monthly thereafter to ensure compliance.
The audit results will be reviewed at the monthly Quality Assurance meeting to identify if any further corrective action is needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation attached.

131f - Fire Extinguisher Inspection

1. **Requirements**

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The 2 fire extinguishers in the SDCU courtyard have not been inspected by a fire safety expert since September 2019.

Plan of Correction **Accept**

Maintenance staff removed one of the fire extinguishers in the SDCU smoke area. Two extinguishers in this area are not necessary (see attached photo 6). Maintenance replaced the second extinguisher with a compliant extinguisher we had extra on hand on 3/4/21 (see attached photo 7).
The Administrator performed an audit of fire extinguisher to ensure compliance on 3/5/21 (see attached fire extinguisher audit).
Johnson Control our fire safety inspection vendor was schedule to come for a re-inspection to complete the removed fire extinguisher inspection an a couple extra we had on hand. The re-inspection was completed on 3/11/21 (see attached acknowledgement of service visit).
Re-education was provided to maintenance staff completed by 3/12/21 (see attached training record).
The administrator/designee will perform a monthly audit x 3 months then quarterly thereafter to ensure compliance. The audit results will be reviewed at the monthly Quality Assurance meeting to identify if any further corrective action is needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation attached.

182c - Medication Administration

1. **Requirements**

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
1. Identify the correct resident.
2. If indicated by the prescriber’s orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident’s hand.
6. Place the medication in the resident’s hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 3/3/21 at 4:40 pm, resident #1 was observed with a medication cup containing 5 Lactaid Fast Acting Oral Tablets sitting on the tray on ██ wheelchair. Direct care staff person A had dispensed the medications to resident #1, and was at the other end of the hallway. Interviews with resident #1 and with direct care staff person A indicate staff person A does not observe the resident taking ██ pills daily before dinner because the resident prefers taking the medication with ██ to the dining room. Resident #1's most recent medical evaluation, dated 5/29/20, indicates the resident cannot self-administer medications.

182c - Medication Administration *(continued)*

Plan of Correction **Accept**

The Director of Wellness provided immediate verbal re-education to Staff person A. The Director of wellness spoke with Resident 1 who expressed ■ wish to self-administer this medication. A self-administration assessment was performed which indicated Resident 1 is capable to self-administrate (see attached Resident 1 supporting documentation). Request was sent to PCP for Resident 1 to have approval to self-admin. Facility received orders to allow Resident 1 to self-administrate Lactaid Fast Acting Oral Tablets and one other medication (see attached Resident 1 supporting documentation). Rasp was updated to reflect this change (see attached Resident 1 Supporting documentation). Staff re-education was performed on this requirement for medication aides (see attached inservice training record).

Director of wellness/Resident Care Manger will perform a random observation audit x 3 months then quarterly of medication passes to ensure compliance. The audit will be reviewed at the Quality Assurance monthly meeting to dentify if any further corrective action is needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting documentation attached.

183b - Meds and Syringes Locked

1. **Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 3/4/21 at 3:50 pm, numerous medications were stored in resident #3's unlocked and unattended bedroom, to include a tube of Biofreeze cream on ■ nightstand, a Biofreeze roll-on, icy hot patches and a tube of Calmoseptine ointment in ■ nightstand drawer.

Plan of Correction **Accept**

The Director of Wellness re-educated resident #3 of the requirement to keeping medication secure at all times and what options are available to do so. Resident # 3 does not want a lock box or to keep medication locked in cabinet, the resident chooses to lock room door any time ■ leaves the room attended. The Director of wellness performed audits of resident that self-administer to ensure compliance (see attached medication security audit). Staff re-education was performed on this requirement and completed by 3/12/21. The Director of Wellness/Resident Care Manager will perform random weekly audits x 4 months then monthly thereafter to ensure compliance. The audit results will be reviewed at the monthly Quality Assurance meeting to identify if any further corrective action is needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation attached.

185a - Implement Storage Procedures

1. **Requirements**

2600.

185a - Implement Storage Procedures *(continued)*

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

On 3/1/21 at 5:19 am, resident #1's blood sugar reading was 168; however, the resident's March 2021 medication administration record (MAR) indicates a blood sugar reading of 188.

Plan of Correction **Accept**

In review of this error, it was identified as a documentation error (see attached Blood sugar chart note by staff). Immediate verbal re-education was provided by the Director of Wellness to both staff persons involved. The Director of Wellness performed an audit of residents requiring glucose monitoring to ensure compliance (see attached blood sugar monitoring audit). The Director of Wellness/Resident Care Manager will perform random weekly audits x 4 months then monthly thereafter to ensure compliance. Medication Aide re-education was provided on this requirement and completed by 3/12/21 (see attached inservice medication aides). The audit results will be reviewed at the monthly Quality Assurance meeting to identify if any further corrective action is needed.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Supporting Documentation attached.