Department of Human Services
Bureau of Human Service Licensing

September 1, 2022

BROOKE GROVE FOUNDATION INC
18100 SLADE SCHOOL ROAD
SANDY SPRING, MD, 20860

RE: REST ASSURED RESIDENTIAL LIVING CENTER
1137 SHIRLEY'S HOLLOW ROAD
MEYERSDALE, PA, 15552
LICENSE/COC#: 32132

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/17/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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: *REST ASSURED RESIDENTIAL LIVING CENTER* **License #**: *32132* **License Expiration**: *12/07/2021*

Address: *1137 SHIRLEY'S HOLLOW ROAD, MEYERSDALE, PA 15552*

County: *SOMERSET* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *BROOKE GROVE FOUNDATION INC*

Address: *18100 SLADE SCHOOL ROAD, SANDY SPRING, MD, 20860*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/18/2007* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *47* **Waking Staff**: *35*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/17/2021*

Inspection Dates and Department Representative

08/17/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *33* **Residents Served**: *26*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Building* **Capacity**: *33* **Residents Served**: *26*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older**: *26*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *21* **Have Physical Disability**: *0*

Inspections / Reviews

08/17/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/13/2021*

07/29/2022 - POC Submission

Inspection (continued)

Reviewe | **Follow-Up Type**: *POC Submission* | **Follow-Up Date**: *08/05/2022*

08/02/2022 - POC Submission

Reviewe | **Follow-Up Type**: *Document Submission* | **Follow-Up Date**: *08/09/2022*

09/01/2022 - Document Submission

Reviewer | **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

Carbon monoxide detectors are not installed in close proximity of, but not less than 15 feet from the 3 gas-fired boilers in the home as required by the Care Facility Carbon Monoxide Standards Act, effective 9/23/16.

The carbon monoxide detectors for Furnace Rooms #1 and #3 do not meet the requirement of not less than 15 feet from the fossil fuel-burning device inside the room, or just outside of the furnace room, to be at least 15 feet from the fossil fuel-burning device.

There is no carbon monoxide detector for Furnace Room #4 which houses a gas-fired boiler.

Plan of Correction ***Accept***

On day of visit, 8/21/21, all detectors were moved and placed 15 feet from boiler. This regulation was changed on the 1st day of August and the inspection occurred on the 17th, unware of changes thus the reason for the previous regulatory guide following. Detector was found and placed by #4. 15 feet away.

Completion Date: *07/29/2022*

Document Submission ***Implemented***

On day of visit, 8/21/21, all detectors were moved and placed 15 feet from boiler. This regulation was changed on the 1st day of August and the inspection occurred on the 17th, unware of changes thus the reason for the previous regulatory guide following. Detector was found and placed by #4. 15 feet away.

88a - Surfaces

1. Requirements

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

Description of Violation

The second means of egress from the second floor is a wooden deck and stairway. The second step from the top has a metal edge strip which is loose and creates a potential tripping hazard.

Plan of Correction ***Accept***

Maintenance replaced edges stripping on 11/04/2021
Maintenance and management assess decking and have resurfaced the steps and landings. Part of the maintenance monthly assessments(walk around) (Visual assessment) (documentation) include the outdoor area of the decking going forward to assess for loose areas and tripping hazards.

Completion Date: *07/29/2022*

Document Submission ***Implemented***

Maintenance replaced edges stripping on 11/04/2021
Maintenance and management assess decking and have resurfaced the steps and landings. Part of the

88a - Surfaces (continued)

maintenance monthly assessments(walk around) (Visual assessment) (documentation) include the outdoor area of the decking going forward to assess for loose areas and tripping hazards.

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

There was no source of light that can be turned on/off at bedside for

Plan of Correction ***Accept***

Lamps were placed in rooms missing them at the time identified during inspection on 8/17/21
Weekly room inspections are completed by DON and Housekeeping to ensure that the lamps are in place.
Maintenance does monthly checks on lamps for lighting and assurance of working condition to adequate as well as location.
Staff have been educated on lamp placement and adequate lighting for residents on 09/10/2021 and ongoing in in-services.

Completion Date: *07/29/2022*

Document Submission ***Implemented***

Lamps were placed in rooms missing them at the time identified during inspection on 8/17/21
Weekly room inspections are completed by DON and Housekeeping to ensure that the lamps are in place.
Maintenance does monthly checks on lamps for lighting and assurance of working condition to adequate as well as location.
Staff have been educated on lamp placement and adequate lighting for residents on 09/10/2021 and ongoing in in-services.

141a 1-10 Medical Evaluation Information

1. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The medical evaluation for Resident #1, with exam does not have

141a 1-10 Medical Evaluation Information (continued)

The medical evaluation for Resident #4 does not have the [redacted].

Plan of Correction ***Accept***

LPN will ensure all data fields are completed on medical DME at time of acceptance and reviewed quarterly for accuracy. LPN has checklist that provides details to the DME and this is reviewed with another member of management. Upon receipt of the DME the LPN reviews the DME for accuracy, if items are missing she then reviews this with the attending MD. Items left blank are revisited with MD and the LPN then ensures that the DME is accurate giving it to the Administrator to review for final step.

Completion Date: *07/29/2022*

Document Submission ***Implemented***

LPN will ensure all data fields are completed on medical DME at time of acceptance and reviewed quarterly for accuracy. LPN has checklist that provides details to the DME and this is reviewed with another member of management. Upon receipt of the DME the LPN reviews the DME for accuracy, if items are missing she then reviews this with the attending MD. Items left blank are revisited with MD and the LPN then ensures that the DME is accurate giving it to the Administrator to review for final step. Please find chart audit form done quarterly and upon receipt of forms.

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 is prescribed [redacted]. On [redacted] these medications were not available in the home.

Plan of Correction ***Accept***

LPN will ensure to have all medications prescribe available for each and every residents with monthly audits being conducted with documentation of such.
LPN's ensure a prescription is obtained for medications and filed in residents file and one other source. The medications prescription is faxed to pharmacy and the LPN ensure that it is on the MAR. Once on the MAR the LPS ensures that it is available for residents. LPN weekly check residents medication to ensure tha the medications are available, not out of date, and the right dose, right medication, and right route for the residents. Since the home employees 2 LPN's they are the primary responsible individuals for medication availability. Both were educated on their duties and responsibilities of ensuring that all medication prescribed are on the eMAR and available for every resident with accuracy quality checks done by Administrator and each LPN weekly.

Completion Date: *07/29/2022*

Document Submission ***Implemented***

LPN will ensure to have all medications prescribe available for each and every residents with monthly audits being conducted with documentation of such.
LPN's ensure a prescription is obtained for medications and filed in residents file and one other source. The medications prescription is faxed to pharmacy and the LPN ensure that it is on the MAR. Once on the MAR the LPS

185a - Implement Storage Procedures (continued)

ensures that it is available for residents. LPN weekly check residents medication to ensure tha the medications are available, not out of date, and the right dose, right medication, and right route for the residents. Since the home employees 2 LPN's they are the primary responsible individuals for medication availability. Both were educated on their duties and responsibilities of ensuring that all medication prescribed are on the eMAR and available for every resident with accuracy quality checks done by Administrator and each LPN weekly.

231b - Medical Evaluation

1. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident 1 was admitted to the [redacted] *The resident's medical evaluation, with exam date* [redacted]

Plan of Correction ***Accept***

DME to be monitor paperwork to ensure all fields are completed and appropriately assigned documentation need for SDCU. This will be monitored quarterly and reviewed to ensure accuracy.
Quality checks are done monthly on DME by three individuals both LPN's and Administrator. Staff were educated on accuracy of DME and the visual assessment of the DME to include that all boxes and areas are completed with accuracy on 9/10/2021
3 individuals are responsible for the accuracy and quarterly quality assessment of DME's: Administrator, LPN, and DON

Completion Date: *07/29/2022*

Document Submission ***Implemented***

DME to be monitor paperwork to ensure all fields are completed and appropriately assigned documentation need for SDCU. This will be monitored quarterly and reviewed to ensure accuracy.
Quality checks are done monthly on DME by three individuals both LPN's and Administrator. Staff were educated on accuracy of DME and the visual assessment of the DME to include that all boxes and areas are completed with accuracy on 9/10/2021
3 individuals are responsible for the accuracy and quarterly quality assessment of DME's: Administrator, LPN, and DON
Please find established chart audits for all residents done quarterly and upon receipt of forms

233c - Key-Locking Devices

1. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the second floor rear exit door and first floor rear exit.
The keypad number posted at the front "Farmhouse" door and the first floor exit by the kitchen was not the correct keypad code.

233c - Key-Locking Devices (continued)

Plan of Correction ***Accept***

On 08/17/2021 during the inspection, all codes were corrected and posted by key pads. On going code posting reviews will be conducted to ensure that they are posted.
Life Enrichment Coordinator is responsible for door code posting and monthly does an assessment of these codes posted and displayed. Administrator does a walk through of building along with maintenance weekly to assess for door code accuracy and visual display.
Completion Date: *07/29/2022*

Document Submission ***Implemented***

On 08/17/2021 during the inspection, all codes were corrected and posted by key pads. On going code posting reviews will be conducted to ensure that they are posted.
Life Enrichment Coordinator is responsible for door code posting and monthly does an assessment of these codes posted and displayed. Administrator does a walk through of building along with maintenance weekly to assess for door code accuracy and visual display.

183e - Storing Medications

1. Requirements

2600.
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 8/17/21, [redacted]. According to the manufacturer's instructions, [redacted] be discarded 31 days after opening.

Repeated Violation - 7/10/19

Plan of Correction ***Accept***

Weekly audits will be conducted by LPN and Administrator to ensure that all insulin is labeled correctly and kept for only 31 days after opened.
Step 1: Date insulin when opened
Step 2: LPN to monitor insulin for time frames of use and dispose of unused amount after the recommended date of time of use.
Step 3: Staff were educated at every diabetic class on insulin dating and use and discarding (ongoing).
Administrator to monitor weekly to ensure that insulin is in compliance with steps and inspection of insulin in medical cart and refrigerator.
Diabetic class given yearly. Staff educated monthly on this topic at staff trainings.
Completion Date: *07/29/2022*

Document Submission ***Implemented***

Weekly audits will be conducted by LPN and Administrator to ensure that all insulin is labeled correctly and kept for only 31 days after opened.
Step 1: Date insulin when opened
Step 2: LPN to monitor insulin for time frames of use and dispose of unused amount after the recommended date of time of use.
Step 3: Staff were educated at every diabetic class on insulin dating and use and discarding (ongoing).

183e - Storing Medications (continued)

Administrator to monitor weekly to ensure that insulin is in compliance with steps and inspection of insulin in medical cart and refrigerator.
Diabetic class given yearly. Staff educated monthly on this topic at staff trainings.