Department of Human Services
Bureau of Human Service Licensing

June 22, 2022

[redacted], EXECUTIVE DIRECTOR

RE: FRITZINGERTOWN SENIOR LIVING COMMUNITY
159 SOUTH OLD TURNPIKE ROAD
DRUMS, PA, 18222
LICENSE/COC#: 20166

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/01/2022, 02/02/2022, 02/03/2022, 02/04/2022, 02/09/2022 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

Facility Information

Name: *FRITZINGERTOWN SENIOR LIVING COMMUNITY* **License #**: *20166* **License Expiration**: *12/19/2022*

Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA 18222*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *LAKEWOOD SENIOR LIVING-DRUMS LLC*

Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA, 18222*

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

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**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *02/04/2022*

Inspection Dates and Department Representative

02/01/2022 - On-Site: [redacted]
02/02/2022 - On-Site: [redacted]
02/03/2022 - On-Site: [redacted]
02/04/2022 - Off-Site: [redacted]
02/09/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *164* **Residents Served**: *83*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Willows* **Capacity**: *60* **Residents Served**: *23*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

02/01/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/18/2022*

04/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/08/2022*

06/22/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

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

On the following dates, a cash disbursement was made to the specified residents. However, the home did not obtain the resident signature for the receipt of the disbursement:
- *Resident #1 on 4/20/21; 5/5/21; 7/30/21; 10/9/21; and 1/10/22*
- *Resident #2 on 3/27/21; 5/7/21; 8/13/21; 11/30/21; and 12/22/21*

Plan of Correction ***Accept***

Why did it happen:
Residents were unable to sign receipt of disbursement to hairdresser for services rendered due to cognitive /physical abilities.
What was done to immediately fix the problem:
Verbal confirmation of disbursements was obtained by the Executive Director. Receipt was then documented as an "inability to sign" and witnessed by Exec Director and Business Office Manager.
Plan of Correction :
Resident Care Coordinators, Receptionist and Business Office Manager were re-inserviced in the requirements of this regulation. If a resident is unable to sign ,a notation must be made documenting such, and witnessed by two persons.
Resident Care Coordinator will monitor daily for compliance to regulation x 2 weeks
Business Office Manager will monitor weekly x 4 weeks.
Executive Director will monitor monthly x 2 months.
Copy of in-inservicing attached.
Completion Date: *02/15/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed

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

The home's designated resident smoking area was covered in approximately 1-2 inches of snow at time of inspection.

The ramp located on the right side of the Oaks building was covered in approximately 1-2 inches of snow at time of inspection.

100b - Removal Snow/Obstructions (continued)

There was approximately 1 inch of snow/ice mix leading from the emergency exit located by resident room 15 in the secured dementia unit.

There was approximately 1 inch of snow/ice mix leading from the emergency exit located in the secured dementia unit's dining room.

Plan of Correction ***Accept***

Why did it happen:
Maintenance staff had shoveled and applied ice melt which melted ice -the remaining precipitation then froze again.
What was done to immediately fix the problem:
Ice melt was applied to the affected areas and then shoveled repeatedly until no ice/snow remained.
Plan of Correction:
Maintenance staff was re-inserviced that any exit utilized by residents/staff for evacuation of facility in an emergency must take priority with snow/ice removal.

Marketing Director will monitor daily for compliance to regulation x 2 weeks
Director of Nursing will monitor weekly x 4 weeks.
Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/15/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed

103i - Outdated Food

1. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There were 4 large containers of plain Yoplait brand yogurt in the home's walk-in fridge with a "Best By" date of 1/21/2022.

103i - Outdated Food *(continued)*

Plan of Correction ***Accept***

Why did it happen:

Yogurt, although labeled "Best By" was not expired due to manufacturer's standards and were being used in recipes requiring yogurt.

What was done to immediately fix the problem:

Yogurt was disposed of by Food Service Director.

Plan of Correction:

Dietary staff was re-inservced in the requirements of this regulation. Foods will be disposed of if "Best By" date is reached.

Food Service Director will monitor daily for compliance to regulation x 2 weeks

Director of Nursing will monitor weekly x 4 weeks.

Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/16/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed 04/02/2022

132d - Evacuation

1. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

Per resident interviews, in inclement weather residents do not fully evacuate to the outside of the building or to the opposite personal care building as stated in the home's annual fire safety inspection. Residents stated that they congregate near the doors.

132d - Evacuation (continued)

Repeated Violation

Plan of Correction ***Accept***

Why did it happen:

Employees complied with residents' requests to avoid inclement weather and temperature extremes in a "drill" exercise.

Plan of Correction:

All staff were re-inservced in the requirements of this regulation. During temperature extremes or inclement weather residents will be fully evacuated to the fire- safe and sheltered area of our alternate building as opposed to the exterior designated meeting place.

Marketing Director will monitor monthly for compliance to regulation x 2 months

Director of Nursing will monitor monthly x 4 months

Executive Director will monitor monthly x 6 months.

Copy of in-inservicing attached.

Completion Date: *02/16/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

Also please include a copy of the home's Fire Drill Log since the Renewal Inspection.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed

144c1 - Smoking Area Guidelines

1. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

Employees of the home are permitted to smoke in their cars. A can of cigarette butts was found outside of the

144c1 - Smoking Area Guidelines (continued)

emergency exit located near the laundry room in the secured dementia unit, and 2 cigarette butts were found on the ground near this can. This is not a permitted designated smoking area.

Plan of Correction ***Accept***

Why did it happen:
Employees /visitors did not comply to facility smoking policy.

What was done to immediately fix the problem:

Cigarette butts and vessel used for extinguishing cigarette butts was removed by Maintenance Director.

Plan of Correction:
All staff re-inserviced in the requirements of this regulation as well as the facility "Smoking Policy". Violators will be subject to disciplinary action.

Maintenance Director will monitor daily for compliance to regulation x 2 weeks

Director of Marketing will monitor weekly x 4 weeks.

Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/15/2022*

Update: *04/01/2022*
Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***
Verification was reviewed

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
Resident #3 is assessed to self-administer medications. A bottle of [redacted] was found on Resident #3's kitchen counter. Resident #3 does not store this medication in a locked area and stated they do not lock their bedroom door when they leave their bedroom.

Plan of Correction ***Accept***
Why did it happen:

183b - Meds and Syringes Locked (continued)

Although resident was aware of facility requirements for self -administration of medications, resident stated did not always lock door to his apartment.

What was done to immediately fix the problem:
Resident was re-educated in the facility requirements for self -administration of medications,

Plan of Correction:
All staff re-inserviced in the requirements of the facility policy for self -administration of medications, and the requirement of this regulation, including cueing, prompting and monitoring of resident's compliance to this policy.

Resident Care Coordinator will monitor daily for compliance to regulation x 2 weeks

Director of Marketing will monitor weekly x 4 weeks.

Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/16/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed

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 #4 is prescribed Acetaminophen [redacted] This medication was not available at time of inspection.

Plan of Correction ***Accept***

Why did it happen:
Resident's responsible party has requested to purchase and deliver OTC medication for this resident. RP was notified that resident needed [redacted] delivered and agreed to deliver the medication but had not done so at time of inspection.

What was done to immediately fix the problem:

185a - Implement Storage Procedures (continued)

RP was again notified of need for this med and was informed if medications not delivered in manner to avoid depletion of medication, medication will be ordered from facility pharmacy provider. Tylenol was delivered by RP on 02/02/2022

Plan of Correction:

All staff re-inserviced in the requirements of the facility policy and the requirement of this regulation. Should family not deliver medication in a manner to avoid depletion of medication, that medication is to be ordered from facility pharmacy provider.

Resident Care Coordinator will monitor daily for compliance to regulation x 2 weeks

Director of Nursing will monitor weekly x 4 weeks.

Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/15/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed

187a - Medication Record

1. Requirements

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

Description of Violation

Resident #5 is prescribed [redacted] with parameters to hold the medication if his/her heart rate is below 55 bpm. The home is not recording Resident #5's daily heart rate.

187a - Medication Record (continued)

Resident #6 is prescribed [redacted]. The resident's medication record (MAR) states to give one 25mg daily. The prescription bottle states to give one half of a 50mg tablet daily, to equal a 25mg dose. Per staff interviews, the prescription bottle is the correct order.

Plan of Correction ***Accept***

Why did it happen:

Although staff state they did monitor pulse rate for dose of medication and it parameters were followed ,several med trained staff personnel did not document pulse rate on MAR.
Pharmacy printed MAR printed dose to be 25 mg (one tab) as opposed to 1/2 of a 50 mg tablet (25mg).

What was done to immediately fix the problem:

MAR was amended to add entry to allow documentation of pulse rate for this medication.
MAR was amended to reflect directions as written on prescription bottle.

Plan of Correction:

All staff re-inserviced in the requirements of the facility policy and the requirement of this regulation. Should vital sign parameter be required, vital sign must be documented at time of administration of medication.
When transcribing medication orders the MAR must match the directions of the prescriber.

Resident Care Coordinator will monitor daily for compliance to regulation x 2 weeks

Director of Nursing will monitor weekly x 4 weeks.

Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/15/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed

227g -Support Plan Signatures

1. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

Resident #1, support plan (RASP) dated 7/3/21, and Resident #7, RASP dated [redacted] did not sign their RASPs. There was no further indication that the residents refused to sign or were unable to sign their RASPs.

Plan of Correction ***Accept***

Why did it happen:

Resident's were unable to sign or initial support plan due to cognitive/physical disabilities ,however documentation of such was not provided.

What was done to immediately fix the problem:

RASPS were re-presented to residents and verbal acknowledgement was received. RASP was then documented as "unable to sign " and witnessed by Executive Director and Business Office Manager

Plan of Correction:

Resident Care Coordinators were re-inserviced in the requirement of this regulation. If resident is unable to sign acknowledgement of receipt of RASP ,inability to sign must be documented and witnessed by two people.

Director of Nursing will monitor weekly x 4 weeks.

Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/16/2022*

Update: *04/01/2022*

Please send in a copy of the signed support plan in Step 2.
Also please note in Step 2 that verifications were reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed

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.

233c - Key-Locking Devices *(continued)*

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted by the locked door located near the laundry room in the secured dementia unit.

Plan of Correction ***Accept***

Why did it happen:

Resident of secured dementia removed posted picture frame which addressed entry code directions. (This picture frame was found in resident belongings).

What was done to immediately fix the problem:

Directions of entry exit code was immediately reposted and secured.

Plan of Correction*:*

All staff were re-inserviced in the requirement of this regulation. Directions for operation of locking devices must be posted at all times.

Resident Care Coordinators will monitor daily for compliance to this regulation.
Director of Nursing will monitor weekly x 4 weeks.
Executive Director will monitor monthly x 2 months.

Copy of in-inservicing attached.

Completion Date: *02/15/2022*

Update: *04/01/2022*

Please note in Step 2 that verification was reviewed in Step 1.

AG, 4-1-22

Document Submission ***Implemented***

Verification was reviewed