

Department of Human Services  
Bureau of Human Service Licensing

August 19, 2022

[REDACTED], ADMINISTRATOR  
[REDACTED]

8221 LAMOR ROAD

ATTN [REDACTED]

MERCER, PA, 16137

RE: QUALITY LIFE SERVICES - MERCER  
8221 LAMOR ROAD  
MERCER, PA, 16137  
LICENSE/COC#: 46050

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/09/2022, 03/10/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
[REDACTED]

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: *QUALITY LIFE SERVICES - MERCER* License #: *46050* License Expiration: *06/14/2022*  
Address: *8221 LAMOR ROAD, MERCER, PA 16137*  
County: *MERCER* Region: *WESTERN*

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: *COUNTRYSIDE CONVALESCENT HOME LIMITED PARTNERSHIP*  
[REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *12/04/2003* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *18* Waking Staff: *14*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal* Exit Conference Date: *03/10/2022*

**Inspection Dates and Department Representative**

*03/09/2022 - On-Site* [REDACTED]  
*03/10/2022 - Off-Site* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *36* Residents Served: *9*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Memory Care* Capacity: *36* Residents Served: *9*

**Hospice**

Current Residents: *1*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *9*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *9* Have Physical Disability: *0*

**Inspections / Reviews**

**03/09/2022 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/26/2022*

Inspections / Reviews *(continued)*

04/04/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/06/2022*

04/11/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *04/22/2022*

08/19/2022 - Document Submission

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

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 3/9/22, the home's current license inspection summary, dated 4/14/21, was not posted in a conspicuous and public place in the home. The 4/14/21 licensing inspection summary was in a binder at the nurse station in the hallway of the licensed assisted living area outside of the SDCU.

On 3/9/22, a copy of the Department of Public Welfare Chapter 2600 Regulations was posted in a locked bulletin board in the entrance area of the Secure Dementia Care Unit (SDCU).

Plan of Correction

Accept

The Annual PC Inspection Summary Binder will be moved and displayed by the locked bulletin board in the common room in Memory Lane and will be freely accessible for residents, visitors and Department to view. This will be completed by 4-1-2022. A copy of the Department of Public Welfare Chapter 2600 Regulations will be removed from the locked bulletin board and posted and posted on the outside of the locked bulletin board to be freely accessible for residents, visitors and Department to view. This will be completed by 4-1-2022. This will be audited by the PCHA/designee on a weekly basis for 1 month then monthly for 2 months. Education will be provided to PCHA. Results will be reported to the QAPI Committee.

Completion Date: 04/01/2022

Document Submission

Implemented

documentation attached

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

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The home has 4 gas boilers in the basement and 3 gas dryers in the laundry room, located in the licensed assisted living area of the home that is adjacent to this licensed SDCU. The carbon monoxide alarm in this areas is approximately 39" from the boilers.

Plan of Correction

Accept

2600.18

Applicable Health and Safety Laws-A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

3-9-2022 The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The home has 4 gas boilers in the basement and 3 gas dryers in the laundry room, located in the licensed assisted living area of the home that is adjacent to this licensed secured dementia unit. The carbon monoxide alarm in this area is approx. 39" from the boilers

3-29-2022 Plan of Correction

18 - Compliance With Laws (continued)

The PCHA/designee and Maintenance Director will be educated on this regulation. The maintenance Director has purchased battery operated CO2 detectors that will be installed per regulatory compliance in the areas found to be deficient. These CO2 detectors will be placed on the preventative maintenance list for battery changes and function of these CO2 detectors.

The Maintenance Director will audit the placement of these CO2 detectors weekly for 1 month then monthly for 2 months. This will be completed by 4-1-2022 Results will be reported to the QAPI Committee.

**Completion Date:** 04/01/2022

**Document Submission**  
documentation attached

**Implemented**

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

**Description of Violation**

Contracted staff person A, whose first day of work was [REDACTED] did not receive orientation training on any of the required topics.

**Plan of Correction**

*Plan of Correction: All contracted staff persons will be oriented on 1) Evacuation procedures 2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable. 3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire. 4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable. 5) The location and use of fire extinguishers. 6) Smoke detectors and fire alarms. 7) Telephone use and notification of emergency services.*

*This education will be provided in writing, located in an education binder and will be completed on or before the 1st day of employment. The employee will sign off on this education. All documentation will be placed in employment files. Education will be provided for the H.R. Director regarding this violation. This education will be audited by the H.R. Director/designee weekly for 1 month then monthly for 2 months. Results will be reported to Quality Assurance Performance Improvement Committee.*

*Substitute Staff Member A (contracted staff) has been oriented on the education pertaining to regulation 2600.65(a) (1-7). A copy of this education is kept in the employees employment file.*

*e add a step for if/when staff person A received this orientation. Also, please write your entire plan when you resubmit, not just the step you are adding.*

**Completion Date:** 04/06/2022

**Document Submission**  
Document attached

**Implemented**

65b - Rights/Abuse 40 Hours

1. Requirements

2600.

**65b - Rights/Abuse 40 Hours (continued)**

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

**Description of Violation**

*Contracted staff person A completed his/her 40th scheduled work hour. However, this staff person did not complete any training in the required topics.*

*Staff person B completed his/her 40th scheduled work hour. However, this staff person did not complete any training in the required topics.*

**Plan of Correction**

**Accept**

2600.65.b

*Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes 1) Resident rights. 2) Emergency medical plan. 3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act. 4) Reporting of reportable incidents and conditions.*

*3-9-2022 during annual inspection contracted staff person A completed his/her 40th scheduled work hour. However, this staff person did not complete any training in the required topics.*

*Staff person B completed his/her 40th scheduled work hour. However, this staff person did not complete any training in the required topics.*

*Substitute Staff Member A [REDACTED] has been oriented on the education pertaining to regulation 2600.65(b) (1-4). A copy of this education is kept in the employees employment file.*

*Staff Person B has terminated [REDACTED] employment with Quality Life Services shortly after the Annual Inspection 3-9-22. This training step was not completed on this employee.*

**Completion Date:** 04/06/2022

**Document Submission**

**Implemented**

*document attached*

**102d - Grab/Hand/Assist Bar/Slip-Resistant Surface**

**1. Requirements**

2600.

102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

**Description of Violation**

*There was no grab bar, hand rail or assist bar in the common bathroom located by bedroom #205.*

**Plan of Correction**

**Accept**

2600.102.d

*Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.*

*3-9-2022 there was no grab bar, hand rail or assist bar in the common bathroom located by bedroom #205.*

*3-29-2022 Plan of Correction*

*The Maintenance Director has ordered permanently installed grab bars to be installed as soon as they are delivered in the common bathroom located by bedroom #205. Existing over the toilet seat riser with handrails will remain in*

**102d - Grab/Hand/Assist Bar/Slip-Resistant Surface (continued)**

*place until permanent grab bars are installed. Education will be provided to staff to ensure grab bars are in place. Audits will be completed of presence of grab bars weekly for 4 weeks, then monthly for 1 month. Results will be reported to QAPI Committee.*

**Completion Date:** 05/01/2022

**Document Submission**

**Implemented**

*document attached*

**105g - Lint Removal and Duct Cleaning**

**1. Requirements**

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**

*On 3/9/22, there was an approximate 1/8 inch accumulation of lint in the lint trap of each of the three dryers in the shared laundry room located in the licensed assisted living area. There were no clothes in the dryer at the time.*

**Plan of Correction**

**Accept**

*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.*

*3-9-2022 during the annual inspection there was an approximate 1/8 inch accumulation of lint in the lint trap of each of the three dryers in the shared laundry room located in the licensed assisted living area. There were no clothes in the dryer at the time.*

*3-29-2022 Plan of Correction*

*Lint trap of each dryer immediately cleaned out by maintenance director. Education for the Housekeeping Director and Laundry Staff will be provided that 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 manufacturer's instructions. An Audit will be performed by the Housekeeping Director weekly for 1 month then monthly for 2 months. This will be completed by 4-1-2022. Results will be reported to QAPI Committee.*

**Completion Date:** 04/01/2022

**Document Submission**

**Implemented**

*document attached*

**123b - Emergency Procedures Posted**

**1. Requirements**

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

**Description of Violation**

*The home's and the local municipality's emergency procedures were not posted in a conspicuous and public place in the*

**123b - Emergency Procedures Posted (continued)**

home. The emergency plans were in a binder in the hallway of the licensed assisted living area outside of the SDCU.

**Plan of Correction**

**Accept**

2600.123b

Copies of the emergency procedures as specified in 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

3-9-2022 the home's and local municipality's emergency procedures were not posted in a conspicuous and public place in the home. The emergency plans were in a binder in the hallway of the licensed assisted living area outside of the Secured Dementia Unit.

3-29-2022 Plan of Correction

The PCHA/designee and Director of Maintenance will be educated on this regulation. An Emergency Procedures Manual will be placed in the Secured Dementia Unit under and outside of the locked bulletin board. The placement of this Emergency Procedures Manual will be audited by the Director of Maintenance weekly for 1 month then monthly for 2 months. This will be completed by 4-1-2022. Results will be reported to QAPI Committee.

**Completion Date:** 04/01/2022

**Document Submission**

**Implemented**

document attached

**132c - Fire Drill Records**

**1. Requirements**

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

**Description of Violation**

The fire drill record for the drills conducted on 12/15/21, 1/5/22 and 2/16/22 did not include exit routes used, the number of residents evacuated, and the number of staff persons participating in the fire drill.

**Plan of Correction**

**Accept**

2600.132c

A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

3-9-2022 the fire drill record for the drills conducted on 12-15-21, 1-5-22, 2-16-22 did not include exit routes used, the number of residents evacuated, and the number of staff persons participating in the fire drill

3-29-2022 Plan of Correction

The PCHA/designee and the Maintenance Director/designee will be educated on this regulation. The Maintenance Director will use the PA Chapter 2600 Fire Drill Record starting with the fire drill for April 2022. The Maintenance Director will be responsible for completing all the Fire Drill records. The PCHA/designee will be responsible for auditing the Fire Drill Records monthly upon successful completion of each monthly fire drill. Results will be

132c - Fire Drill Records (continued)

reported to QAPI Committee.

**Completion Date:** 04/01/2022

**Document Submission**

**Implemented**

document attached

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**

The home has a safe evacuation time of 4 minutes and 30 seconds, established by a fire safety expert on 9/7/21. However, the fire drill log indicated on 12/15/21, at 1:30 am. residents evacuated in 6 minutes, on 1/5/22, at 10:30 am., residents evacuated in 5 minutes and on 2/16/22, at 2:30 pm. residents evacuated in 6 minutes.

During the fire drill on 12/15/21, at 1:30 am., 1/5/22, at 10:30 am., and 2/16/22, at 2:30 pm., residents evacuated to the interior dining room area of the SDCU. However, this area has not been designated in writing as a fire safe area by a fire safety expert.

**Plan of Correction**

**Accept**

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. 3-9-2022 the home has a safe evacuation time of 4 minutes and 30 seconds, established by a fire safety expert on 9-7-2021. However, the fire drill log indicated on 12-15-21, at 1:30am residents evacuated in 6 minutes, on 1-15-22 at 10:30am residents evacuated in 5 minutes and on 2-16-22 at 2:30pm residents evacuated in 6 minutes During the fire drill on 12-15-21 at 1:30am, 1-5-22 at 10:30am and 2-16-22 at 2:30pm residents evacuated to the interior dining room area of the secured dementia unit. However, this area has not been designated in writing as a fire safe area by a fire safety expert.

3-29-2022 Plan of Correction

The PCHA/designee and the Maintenance Director will be educated on this violation. The Fire Drills performed monthly will comply with the safe evacuation time established by the fire safety expert, and will be documented on the PA Chapter 2600 Fire Drill Record. During every Fire Drill the residents will be evacuated to the safe area located outside of the Secured Dementia Unit as designated by the Fire Safety Expert. The PCHA/designee will audit every monthly Fire Drill Record to ensure successful completion of all information required per this regulation on the Fire Drill Record. Results will be reported to QAPI Committee.

**Completion Date:** 04/01/2022

**Document Submission**

**Implemented**

document attached

162c - Menus Posted

1. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

*The menus posted in the home were not dated. The menus indicated only the week number and the year 2021.*

Plan of Correction

**Accept**

2600.162c

*Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.*

*3-9-2022 during annual inspection it was noted that the menus posted in the home were not dated. The menus indicated only the week number and the year 2021.*

*3-29-2022 Plan of Correction*

*This violation was corrected at the time of the survey on 3-9-2022. Ongoing the current menus shall be posted on the door leading into the kitchen area in Memory Lane for the residents and department to view. Menus will have current dates as to signify current menu week. These dates will be updated at the beginning of each week by the Certified Dietary Manager/designee.*

*Audits will be completed by the Certified Dietary Manager/designee on a weekly basis for a 1 month time period, then monthly for 2 months.*

*Education will be provided to the Certified Dietary Manager/designee as to the above corrective action and audit process. Results will be reported to QAPI Committee.*

**Completion Date:** 03/29/2022

Document Submission

**Implemented**

*document attached*

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

*Resident #1 is prescribed, [REDACTED], 1 spray in both nostrils two times a day. On 3/9/22, the medication, [REDACTED] was labeled as opened on 11/1/21. According to the manufacturer's instructions the medication should be disposed of after 120 sprays.*

Plan of Correction

**Accept**

*2600.183.e—Storing Medications: 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.*

*Plan of Correction: Resident 1) This residents [REDACTED] that was expired was disposed of appropriately at time of survey and new medication ordered from pharmacy. In addition, Quality Pharmacy Guideline Tools are now placed in each medication cart for your reference. These tools advise of expiration dates for medications including*

**183e - Storing Medications (continued)**

eye drops, eye ointments, inhaled medications, liquids, suspensions and insulins. When these type of medications are received from the pharmacy, a "date opened sticker" is to be placed on the container of the medication by the receiving PCA/Med Tech. When these medication are opened this "date opened" sticker will be completed with date and initials by the PCA/Med Tech administering the newly opened medication.

Any medications NOT found on these Quality Pharmacy Guideline Tools placed in each medication cart, the PCA/Med Tech is to notify Quality Pharmacy and receive direction from a pharmacist for the appropriate medication expiration timeline.

An EXPI-DATER Medication Expiration Date Calculator is also placed in each Medication Cart to further assist PCA/Med Techs with expiration date calculation.

A Medication Cart Audit will be done weekly by the PCA/Med Techs, all corrective action needed will be completed by the PCA/Med Techs and then turned into the Assisted Living Administrator for review of audits and the corrective action taken. Results will be reported to Quality Assurance Performance Improvement Committee.

**Completion Date:** 04/06/2022

**Document Submission**  
document attached

**Implemented**

**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 three emergency exit doors from the SDCU; the exit door by the employee bathroom, exit door by bedroom #217 and bedroom #220.

**Plan of Correction**

**Accept**

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.

3-9-22 the directions for operating the home's locking mechanism are not conspicuously posted near the three emergency exit doors from the Secured Dementia Unit, the exit door by the employee bathroom, exit door by bedroom #217 and bedroom #220.

3-29-2022 Plan of Correction

The PCHA/designee and Maintenance Director/designee will be educated on this regulation. The Maintenance Director will place the locking mechanism exit code conspicuously by each emergency exit doors from the Secured Memory Unit that include the exit door from the secured memory unit into the assisted living residence, the exit door by the employee bathroom, exit door by bedroom #217 and the exit door by bedroom #220. The Maintenance Director will be responsible for auditing all the locking mechanism exit doors for the exit code posting weekly for 1 month then monthly for 2 months. Results will be reported to QAPI Committee.

This will be completed by 4-1-2022.

**Completion Date:** 04/01/2022

**233c - Key-Locking Devices** *(continued)***Document Submission*****Implemented****document attached*