Department of Human Services
Bureau of Human Service Licensing

October 11, 2022

[redacted]
ALWAYS ON CARE LLC
[redacted]

RE: ALWAYS ON CARE
600 NORTH LAUREL STREET
HAZELTON, PA, 18201
LICENSE/COC#: 23006

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/06/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk
Human Services Licensing Supervisor

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: *ALWAYS ON CARE* **License #:** *23006* **License Expiration:** *06/03/2023*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

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

Administrator

Name: [redacted] **Phone:** *(908)349-0574* **Email:** [redacted]

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address: *4 FAIRFIELD DRIVE, WILKES-BARRE, PA, 18702*

Phone: *5704557890* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/22/2010* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *19* **Waking Staff:** *14*

Inspection Information

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

Reason: *Interim* **Exit Conference Date:** *09/06/2022*

Inspection Dates and Department Representative

09/06/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served:** *19*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *16*

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

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

Inspections / Reviews

09/06/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/01/2022*

Inspections / Reviews *(continued)*

10/02/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/07/2022*

10/11/2022 - Document Submission

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Through resident interviews it was determined that resident #1 suffered a fall on [redacted] with an injury to the back of the head which required two staples. The home did not report the incident to the department's regional office as required.

Repeat violation from 6/22/22.

Plan of Correction ***Accept***

The Administrator emailed the incident report for Resident 1 on 09/07/2022. The Administrator will ensure all reportable incidents are reported within 24 hours to the personal care regional office by email to the following email address [redacted] Administrator will also keep a hard copy of all Incident Reports in the office. The Administrator has printed the incident form for this incident referenced and placed it in a folder for Incident Reports in the office.

Completion Date: *10/01/2022*

Update: *10/02/2022*

Please include in plan of correction:
Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Please send proof of staff training.

Document Submission ***Implemented***

The Administrator emailed the incident report for Resident 1 on 09/07/2022. The Administrator will ensure all reportable incidents are reported within 24 hours to the personal care regional office by email to the following email address [redacted] and will maintain the responsibility of overseeing Incident Reports and follow-up meetings/training to reduce future incidents. Administrator will also keep a hard copy of all Incident Reports in the office. The Administrator has printed the incident form for this incident referenced and placed it in a folder for Incident Reports in the office and 08/25/2022 reviewed with parties involved if there were any actions the home could take to mitigate this type of incident.

Administrator also reviewed with the Assistant Administrator the outlined steps and guidelines when to submit an incident report on 10/01/2022, and will monitor ongoing compliance.

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 home's fire drill logs on which the drills for 6/28/22, 7/15/22, and 8/1/22 were recorded did not include the time it

132c - Fire Drill Records (continued)

took to evacuate residents during the drill. The home only recorded "under two minutes" in this section.

Plan of Correction ***Accept***

The Administrator/Assistant Administrator will ensure written fire drill records will include the date, time, and the exact amount of time in minutes and seconds it takes 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. The Fire Drill Record – 55 Pa.Code 2600.132(c) will be used to document all fire drills.

Completion Date: *10/01/2022*

Update: *10/02/2022*

Please include in plan of correction:
Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Document Submission ***Implemented***

The Administrator/Assistant Administrator will ensure written fire drill records will include the date, time, and the exact amount of time in minutes and seconds it takes 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. The Fire Drill Record – 55 Pa.Code 2600.132(c) will be used to document all fire drills. Administrator will maintain the responsibility before each month concludes the fire drill was completed and recorded properly, and will monitor ongoing compliance.

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

Resident #2 was admitted to the home on [redacted] *The home did not have a Documentation of Medical Evaluation form (DME) signed by the physician who completed the evaluation until* [redacted]

Repeat violation from 6/22/22.

Plan of Correction ***Accept***

Administrator will ensure a resident shall have a medical evaluation by a physician, physician's assistant or

141a 1-10 Medical Evaluation Information (continued)

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 home contacts a medical provider within 72 hours of resident's admission to request they are evaluated as new patients and the home also requests the provider to document the visit on the DME. The DME will 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. Prior to Resident #2 being admitted to the home a Medical Evaluation was completed on [redacted] and received from [redacted]. Once the home identified the incorrect Medical Evaluation form was completed, the home made arrangements for a medical provider to assess the resident and complete the DME form on [redacted] in a face-to-face visit at the facility with the resident; the provider didn't sign the form at the visit and it was faxed to their office on 09/01/2022 for signature.

Completion Date: *10/01/2022*

Update: *10/02/2022*

Please include in plan of correction:
Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Document Submission ***Implemented***

Administrator is responsible 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 and maintains the responsibility of monitoring for ongoing compliance through monthly audits of resident's records. Administrator/Assistant Administrator contacts a medical provider within 72 hours of resident's admission to request they are evaluated as new patients and the Administrator/Assistant Administrator also requests the provider to document the visit on the DME. The DME will 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.
Prior to Resident #2 being admitted to the home a Medical Evaluation was completed on [redacted] and received from the [redacted]. Once the Administrator identified the incorrect Medical Evaluation form was completed, the Assistant Administrator made arrangements for a medical provider to assess the resident and complete the DME form on [redacted] in a face-to-face visit at the facility with the resident; the provider didn't sign the form at the visit and the Assistant Administrator faxed it to their office on 09/01/2022 for signature.

187a - Medication Record

1. Requirements

187a - Medication Record *(continued)*

2600.

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

13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

On 9/6/22 at 8:00am the following medications were administered to resident #3 but were not initialed on the medication administration record (MAR):
Buspirone 5 mg, Daily Vite tablet, Fluoxetine HCL 20mg, Jardiance 10mg.
Also, the following medications were not initialed as administered on 9/3/22 at 8:00pm:
Arnuity Elipta, Buspirone 5mg, and Trazadone 50mg.

Repeat violation from 06/22/22.

Plan of Correction ***Accept***

Personal Care Home staff who administer medication use an electronic medication record they have to log into to document administering of medications. The login to the electronic MAR serves as the signature. The home's medication record will include the following for each resident for whom medications are administered: Date and time of medication administration, Name and initials of the staff person administering the medication. Persons administering medication will make sure they document in the exceptions section of the MAR if they experience any network or computer issues that do not permit proper documentation in the electronic record. On 09/08/2022 Administrator reviewed with the Assistant Administrator the exceptions section in the MAR to ensure this step was being completed when necessary. Administrator will also ensure all programs and computers are routinely updated to minimize issues documenting in the electronic medication record.

Completion Date: *10/01/2022*

Update: *10/02/2022*

Please include in plan of correction:
Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Please send proof of staff training.

Document Submission ***Implemented***

Personal Care Home staff who administer medication use an electronic medication record they have to log into to document administering of medications. The login to the electronic MAR serves as the signature. The home's medication record will include the following for each resident for whom medications are administered: Date and time of medication administration, Name and initials of the staff person administering the medication. Persons administering medication will make sure they document in the exceptions section of the MAR if they experience any network or computer issues that do not permit proper documentation in the electronic record. On 09/08/2022 Administrator reviewed with the Assistant Administrator the exceptions section in the MAR to ensure this step was being completed when necessary. Administrator will also ensure all programs and computers are routinely updated to minimize issues documenting in the electronic medication record and provide monthly checks to maintain ongoing compliance.