Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

March 9, 2023

[redacted]
LAURELS SENIOR LIVING INC
23 FAITH DRIVE
HAZLETON, PA, 18202

RE: THE LAURELS
23 FAITH DRIVE
HAZLETON, PA, 18202
LICENSE/COC#: 21117

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/06/2022, 12/07/2022, 12/08/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE LAURELS* **License #:** *21117* **License Expiration:** *01/13/2023*

Address: *23 FAITH DRIVE, HAZLETON, PA 18202*

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

Administrator

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

Legal Entity

Name: *LAURELS SENIOR LIVING INC*

Address: *23 FAITH DRIVE, HAZLETON, PA, 18202*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/21/2003* **Issued By:** *L&I*

Type: *I-1* **Date:** *08/15/2022* **Issued By:** *Butler Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *80* **Waking Staff:** *60*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *12/08/2022*

Inspection Dates and Department Representative

12/06/2022 - On-Site: [redacted]
12/07/2022 - On-Site: [redacted]
12/08/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *73*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *73*

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

Have Mobility Need: *7* **Have Physical Disability:** *0*

Inspections / Reviews

12/06/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/03/2023*

02/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/21/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/28/2023*

03/09/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/21/2023*

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

Resident #1 has an order for fluticasone nasal spray daily. On 12/6/22 the medication was not administered. The home did not submit an incident report to the Department regarding the medication error.

Plan of Correction ***Accept (AG - 02/21/2023)***

All medication administration staff were re-educated between 12/12/22 and 12/16/22 regarding following the MAR and properly administering prescribed medications. An incident report was sent to DHS post-inspection on 12/8/22, explaining the medication error. DOW will immediately follow through with reports to DHS if medication errors occur in the future. The administrator and DOW will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff member A hired [redacted] has an online diploma that is not accredited by the Department of Education or the State Department of Education.

Plan of Correction ***Accept (AG - 02/21/2023)***

Staff member A was made aware of the non-accredited GED. [redacted] is currently enrolled in a state-accredited GED program. Staff member A will assist with ADLs until GED completion but not perform ADLs without supervision. The administrator will provide a copy of the GED to DHS upon completing the program. Human resources began reviewing all diplomas and GEDs on 12/19/22 to ensure they are from accredited institutions. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

82a - Poisonous Materials

3. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

A bottle labeled murphy's oil was located on the cleaning cart on the 2nd floor. The bottle did not have the original

82a - Poisonous Materials (continued)

manufacturers label attached.

Plan of Correction ***Accept (AG - 02/21/2023)***

The housekeeping supervisor affixed manufacturers labels to all cleaning bottles 1/2/23 containing Murphy's Oil Soap. The housekeeping supervisor will check all cleaning supplies weekly to ensure correct labels are affixed and visible. The administrator and housekeeping supervisor will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

96c - First Aid Accessible

4. Requirements

2600.
96.c. The first aid kit must be in a location that is easily accessible to staff persons.

Description of Violation

The first aid kits located through out the home are closed with a zip tie. The zip tie needs to be cut off to make the first aid kit accessible in the event of an emergency.

Plan of Correction ***Accept (AG - 02/21/2023)***

The Maintenance director removed zip ties from all first aid kits on 12/8/22. The maintenance director will inspect the first aid kits monthly and document compliance. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

124 - Notice to Fire Department

5. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The notice to the fire department dated 10/25/22 notes the home is serving 23 residents with mobility needs. The home currently serves 7 residents with mobility needs.

Plan of Correction ***Accept (AG - 02/21/2023)***

A letter was mailed to the local fire department on 12/29/22 discussing assistance needed with non-ambulatory residents during an emergency. The maintenance director will update the fire department yearly or as needs change. The administrator will monitor for compliance.
See attached.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

132a - Monthly Fire Drill

6. Requirements

2600.

132a - Monthly Fire Drill *(continued)*

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home did not conduct fire drills in the months of 1/22, 4/22, 7/22 and 10/22. Mock drills were conducted during these times.

Plan of Correction ***Accept (AG - 02/21/2023)***

Beginning January 1, 2023, all monthly fire drills will be unannounced. Documentation will be retained by the Maintenance Director and available upon request. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

132e - Fire Drill Sleeping Hours

7. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home did not conduct an overnight sleeping hours fire drill in 2022.

Plan of Correction ***Accept (AG - 02/21/2023)***

Beginning January 1, 2023, the maintenance director will conduct at least one unannounced fire drill every 6 months during sleeping hours. Documentation will be retained by the maintenance director and made available upon request. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

132h - Designated Meeting Place

8. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

It has been determined through an interview with Ancillary staff member B that during fire drills the residents will evacuate to the hallway outside of the fire safe stairwells instead of going into the fire safe stairwells as required.

Plan of Correction ***Accept (AG - 02/21/2023)***

All fire drills conducted at the facility will require the evacuation of residents to fire-safe areas, including fire-safe stairwells, fire-safe areas on the 1st floor (dining room and front lobby-if deemed safe at the time), or outside of the building to the designated meeting place. Complete evacuation will be conducted monthly and documented by the maintenance director. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

133.1 - Exit Signs

9. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

The following exit doors do not have exit signs posted on or near the doors: 3rd floor exit door near room #318 on either side of the door and the 3rd floor exit door near the laundry room.

Plan of Correction ***Accept (AG - 02/21/2023)***

Temporary Exit signs were placed on 12/29/22 above both sides of the exit door near room 318 and above the door on the side of the 3rd-floor laundry room. Permanent exit signs were purchased on 12/28/22 and will be installed in the areas when delivered to the facility. Arrow was punched out in the existing sign in this area to indicate exits both ways. The maintenance director will ensure signs are installed and in good working condition. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

141b1 - Annual Medical Evaluation

10. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent DME was completed on [redacted], the previous was completed on [redacted]

Plan of Correction ***Accept (AG - 02/21/2023)***

All residents' DMEs will be completed at least annually. To ensure compliance, PCP appointments will be scheduled within two months in advance to secure an appointment around the annual DME date. DOW will review charts monthly to ensure all medical evaluations are completed in a timely manner in compliance with DHS regulations. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

144c2 - Smoking Area Distance

11. 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:
2. 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: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

4 chairs with a fabric on them were located in the resident smoking area. The chairs did not have a California tag attached to them indicating they were fire resistant. The chairs pose a possible fire hazard.

Plan of Correction ***Accept (AG - 02/21/2023)***

The 4 chairs were removed during the DHS inspection on 12/6/22 and replaced with all metal chairs. The maintenance Director will inspect the area daily to ensure no possible fire hazards. The administrator will monitor

144c2 - Smoking Area Distance (continued)

for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

183a - Original Containers and Injections

12. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Staff interviews indicated that when a resident goes out of the building for the day the staff member will pop the medications out of the original container and put the medications into an envelope and label it.

Plan of Correction ***Accept (AG - 02/21/2023)***

All trained med techs were notified to stop removing medications from original containers on 12/12/22. Medication administration staff was re-educated on facility protocols regarding medication procedures for residents leaving the facility for an extended period of time. All medications must remain in their original container with specific instructions for residents or family members to follow regarding administration. DOW will monitor compliance daily.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

183d - Prescription Current

13. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #3's tylenol extra strength expired 1/21.

Resident #4's cough syrup expired 7/22.

Repeat violation: 12/28/21

Plan of Correction ***Accept (AG - 02/21/2023)***

Expired medications were immediately disposed of on 12/7/22. All medication administration staff were re-educated to monitor medication expiration dates, medication disposal protocols, and medication re-ordering. DOW and LPNs will inspect med carts monthly to ensure compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

184a - Resident's Meds Labeled

14. Requirements

184a - Resident's Meds Labeled *(continued)*

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #4 has an order for losartan potassium 25mg daily hold for systolic blood pressure less than 119, and PRN order for an additional 25mg if the systolic blood pressure is more than 140. The label to the medication notes 50mg 1 tablet daily. The label is incorrect.

Plan of Correction ***Accept (AG - 02/21/2023)***

A new label has been provided by our pharmacy on 12/12/22 to reflect the physician's orders. The staff has been re-educated to ensure labeling on medications and the MAR match and follow the physician's orders. DOW will monitor medication changes from physicians daily to ensure correct labeling.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

184b - Labeling OTC/CAM

15. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #2's OTC Tylenol did not have the residents name on the bottle.

Resident #6's OTC viactive and glucosamine-chondroitin liquid did not have the residents name of the bottles.

Plan of Correction ***Accept (AG - 02/21/2023)***

Medications for Residents 2 and 6 were immediately labeled with their full names and room number on 12/7/22. Staff was instructed to use labels for all OTC medications with residents' full names and room numbers. DOW will monitor OTC medications weekly to ensure proper labeling per DHS regulations.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

184c - Sample Prescription Meds.

16. Requirements

2600.
184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

Resident #5 has a sample cequa eye drop. The medication does not include the written instructions from the prescriber.

Plan of Correction ***Accept (AG - 02/21/2023)***

Written instructions from the prescriber were attached to the sample eye drop post inspection on 12/7/22. Staff was educated regarding protocols for sample medications, including labeling and instructions. Staff was informed to bring all sample medications to DOW for proper labeling before medication is placed in the medication cart. DOW

184c - Sample Prescription Meds. (continued)

and the administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

185a - Implement Storage Procedures

17. 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

The homes narcotic count policy is to count narcotics at the change of shift and sign the shift change narcotic count sheet. From 12/1-12/4/22 there was no signatures for any shift. On 12/5 & 12/6/22 the 3pm-11pm shift was the only shift to sign the sheet. Staff interviews indicated that the narcotic count is not always completed with another staff member because the way the shifts overlap, staff will often count by themselves.

Plan of Correction ***Accept (AG - 02/21/2023)***

All medication administration staff were re-educated between 12/12 and 12/16/22 on the proper implementation of signing a narcotic shift change count sheet. Furthermore, the staff was informed the narcotic count is mandatory between shift changes, med tech coming on shift, and med tech leaving the shift. DOW will monitor the narcotic shift change count sheet daily. The new narcotic control sheet is attached.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

187a - Medication Record

18. Requirements

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

Description of Violation

Resident #4 has an order for losartan potassium 25mg daily hold for systolic blood pressure less than 119, and PRN order for an additional 25mg if the systolic blood pressure is more than 140. The bottle of medication is 50mg tablets. The MAR notes 25mg one tablet daily.

Resident #4 has an order for losartan potassium 25mg daily hold for systolic blood pressure less than 119. On 12/2/22 the MAR indicates the systolic blood pressure was 116/78 and that the medication was administered. The medication was withheld, the MAR is incorrect.

Resident #1 has an order for fluticasone nasal spray daily. On 12/6 & 12/7/22 the medication was not administered, but the MAR is initialed by the staff as administered.

Plan of Correction ***Accept (AG - 02/21/2023)***

The MAR was updated to read Losartan 50mg tablets take 0.5 tab (25mg) daily hold for systolic blood pressure less than or equal to 120. The PRN order was discontinued. Medication administration staff was re-educated on

187a - Medication Record (continued)

12/12/22 on perimeters regarding blood pressure monitoring, including not to sign that an unavailable med was administered and to ensure all re-orders are completed immediately. DOW will complete MAR reviews with staff twice a year. Administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

187d - Follow Prescriber's Orders

19. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #4 has an order for losartan potassium 25mg daily hold for systolic blood pressure less than 119, and PRN order for an additional 25mg if the systolic blood pressure is more than 140. On 12/3/22 the systolic blood pressure was 162/86 and on 12/4/22 the systolic blood pressure was 177/79. The additional 25mg was not administered and should have been.

Resident #1 has an order for fluticasone nasal spray daily. On 12/6 & 12/7/22 the medication was not administered.

Repeat violation: 12/28/21

Plan of Correction ***Accept (AG - 02/21/2023)***

Staff was re-educated on 12/12/22 and instructed regarding blood pressure monitoring parameters and when to give additional medication per the physician's orders. Staff was also instructed if a medication is not available, do not sign the MAR as administered and alert DOW or LPN for re-ordering. Per resident #1's request, the nasal spray has been discontinued. DOW will complete MAR reviews with staff twice a year. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

188b - Medication Error Reporting

20. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 has an order for fluticasone nasal spray daily. On 12/6/22 the medication was not administered. The prescriber was not notified regarding the medication error.

Plan of Correction ***Accept (AG - 02/21/2023)***

The PCP for Resident #1 was notified on 12/6/22 that the nasal spray was not given as prescribed. Staff was re-educating regarding all prescribed medications are to be administered as ordered. DOW will monitor daily to ensure compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)

227d - Support Plan Medical/Dental

21. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #7 utilizes a grab assist bar on the residents bed. The RASP dated 3/1/22 is not updated to reflect the residents current care needs.

Repeat violation: 12/28/21

Plan of Correction ***Accept (AG - 02/21/2023)***

Resident #7's RASP was updated immediately to reflect the addition of a grab assist bar and the resident's current needs. When any assistive devices are required due to a change in condition or needs, the RASP will be updated timely per DHS regulations. DOW will review RASPs monthly. The administrator will monitor for compliance.

Licensee's Proposed Overall Completion Date: *01/03/2023*

Implemented (AG - 03/09/2023)