

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

March 13, 2023

[REDACTED]
178 SLAUGHTERHOUSE ROAD
DAYTON, PA, 16222

RE: BACK TO BASICS PERSONAL CARE
215 SLAUGHTERHOUSE ROAD
DAYTON, PA, 16222
LICENSE/COC#: 42718

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/06/2023 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: *BACK TO BASICS PERSONAL CARE* License #: *42718* License Expiration: *05/11/2023*
 Address: *215 SLAUGHTERHOUSE ROAD, DAYTON, PA 16222*
 County: *ARMSTRONG* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *SHERRY STOCKDALE*
 Address: *178 SLAUGHTERHOUSE ROAD, DAYTON, PA, 16222*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *R-4* Date: *08/03/0001* Issued By: *Wayne Twp*

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: *02/06/2023*

Inspection Dates and Department Representative

02/06/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *16* Residents Served: *16*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *2*

Number of Residents Who:
 Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *15*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *3*
 Have Mobility Need: *2* Have Physical Disability: *0*

Inspections / Reviews

02/06/2023 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/18/2023*

02/21/2023 - POC Submission
 Submitted By: [REDACTED] *iar* Date Submitted: *03/03/2023*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/28/2023*

Inspections / Reviews *(continued)*

03/02/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/03/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/03/2023

03/13/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/03/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

81b - Resident Personal Equipment

1. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 2/6/23 there were three large oxygen tanks stored on the floor and not secured in a storage rack or a carrier cart, in the corner by the dresser in bedroom #7.

Plan of Correction

Directed (JW - 02/28/2023)

On 02/06/23 The direct care staff, on duty at the time, and the assist. administrator arranged the oxygen tanks and placed a chair in front of them, so the tanks could not accidentally fall over, until such time a storage rack could be obtained. Administrator monitored the status of the oxygen tanks daily until rack arrived and was installed. Resident ordered a storage rack on 02/06/23, but was notified on 02/14/23 that insurance would not cover the cost. On 02/15/23 the administrator took measurements necessary to have a custom storage rack built. Administrator had access to a wood shop and built and installed the storage rack on 02/19/23. Direct care staff will monitor daily to insure all oxygen tanks are in the storage rack or in a portable tank carrier. (see attached photo)

Directed: By 3/3/23 direct care staff will begin daily monitoring of all oxygen tanks on the premises to ensure all oxygen tanks are properly secured.

J.W. 2/28/23

Directed Completion Date: 03/03/2023

Implemented (JW - 03/13/2023)

132d - Evacuation

2. 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

On 2/6/23 records indicated that the fire drill conducted on 11/23/22 at 9:00 a.m. indicated there were 14 residents in the home however, only 13 residents were evacuated.

On 2/6/23 records indicated that the fire drill conducted on 12/24/22 at 9:00 a.m. indicated there were 14 residents in the home however, only 13 residents were evacuated.

On 2/6/23 records indicated that the fire drill conducted on 1/7/23 at 1:00 p.m. indicated there were 16 residents in the home however, only 14 residents were evacuated.

Plan of Correction

Directed (JW - 02/28/2023)

This discrepancy is one of a documentation error. Fire drills were conducted by assist. administrator on 11/23/22 and 12/24/22. At the time of the drill, the home census was 14, but only 13 residents were present in the home when the alarm was sounded and all were evacuated. One resident not present was with family for the holidays on both

132d - Evacuation (continued)

dates. Assist. administrator documented the current census as total in home, instead of residents at home at the time of drill. The same holds true for the 01/07/23 fire drill. The Home census increased by an additional 2 residents for a total of 16. At the time of the fire drill, at 1pm there were a total of 14 present at the home, and 14 were evacuated. Assist. administrator documented 16 (total census) present rather than the 14 who were home at the time of the drill. On 02/13/23, administrator, met with the staff and assist. administrator to review the proper procedures for conducting fire drills and the proper documentation. Going forward the administrator will monitor the documentation of the fire drills. On 02/13/23 Administrator reviewed the above fire drills and corrected the documentation to reflect actual events. (see attached)

Directed: Beginning 3/1/23 the administrator will monitor and maintain the fire drill documentation and present at the next regular risk management meeting.

J.W. 2/28/23

Directed Completion Date: 03/03/2023

Implemented (JW - 03/13/2023)

181d - Storing Medication**3. Requirements**

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

On 2/6/23 it was observed that resident #1 self-administers medications and stores medications in his/her room. There were multiple unsecured medications stored in the top right dresser drawer in bedroom #7 to include:

*a Combivent Respimat 20mcg/100mcg per actuation inhaler

*a grey albuterol inhaler

*an opened bottle of Fluticasone Propionate 50mcg

*an unopened bottle of Fluticasone Propionate 50mcg

*a Spiriva inhaler 18mcg per capsule

Plan of Correction

Directed (JW - 02/28/2023)

On 02/06/23, direct care staff, on duty at the time, and the assist. administrator, removed all medications from resident #1 room and placed the medications in the locked med cart located in the kitchen, with access by staff only. Staff will take,, resident #1, their medications at the time specified on the MAR for self administration, then return medication to the med cart after completion. Going forward, all self medication residents, shall have their medications stored in the med cart in a secure location (currently in kitchen with access by staff only). On 02/13/23 the administrator reviewed with staff and assist. administrator the procedures and documentation for self medicating residents. Administrator will follow up on documentation and proper storage procedures.

Directed: the administrator will provide the specific date that all self-medicating residents shall have their medications stored in the med cart in a secure location, and the title of the person responsible. J.W. 2/28/23

Directed: The administrator will provide the specific date that the administrator will follow up on documentation and proper storage procedures. J.W. 2/28/23

Directed Completion Date: 03/03/2023

181d - Storing Medication (*continued*)*Implemented (JW - 03/13/2023)*

184a - Resident's Meds Labeled

4. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On 2/6/23 multiple medications for resident #1, which were stored in the resident's bedroom #7, did not have a pharmacy label to include: a grey Albuterol inhaler, Fluticasone Propionate bottle and Combivent Respimat inhaler.

On 2/6/23 the bottle of nitroglycerine sublingual tablets for resident #1, stored in the home's medication cart, did not have a pharmacy label.

On 2/6/23 resident #1 is prescribed Albuterol sulfate 2.5mg/3ml – use one vial via nebulizer by mouth every 6 hours as needed. However, the resident's medication label indicates – Albuterol sulfate 2.5mg/3ml – use one vial via nebulizer every 4 hours as needed.

Plan of Correction*Directed (JW - 02/28/2023)*

See attached. Resident #1 (new resident) admitted [REDACTED] came with the above medications from various pharmacies. Assist. administrator had made several attempts to obtain labels for the medications but was unsuccessful. Current pharmacy will not provide labels for the current meds since they did not fill the scripts. On 02/12/23 the current PCP was contacted and asked to provide a copy of the script which was faxed to the home. (see attached). On 02/06/23, assist administrator and on duty direct care staff, placed a notation on old medications to : "REFER TO MAR" for proper dosage and instructions. On 02/22/23 pharmacy refilled new scripts with labels matching MAR (see attached). Due to insurance, the pharmacy could not refill the scripts until the old supply was exhausted on 02/22/23. Going forward, on duty staff and administrators, will review all new resident med's to insure proper labeling and MAR are in place for unexpired medications that resident may bring with them. A notation of: "REFER TO MAR" for instructions will be placed on medication until such time a refill of medication can be obtained.

Directed: The administrator will provide the specific date that on duty staff and administrators, will review all new resident meds to ensure proper labeling and MAR are in place for unexpired medications that resident may bring with them. J.W 2/28/23

Directed: The administrator will review audit documentation at regular risk management meetings, starting 3/3/23. J.W. 2/28/23

Directed Completion Date: 03/03/2023

Implemented (JW - 03/13/2023)

187d - Follow Prescriber's Orders

5. Requirements

2600.

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

Description of Violation

On 2/6/23 records indicated that resident #2 was prescribed Vitamin D3 1000 IU (25mcg) – take one tab by mouth every day. However, according to staff interviews, the home administered Vitamin D3 2000 IU (50mcg) on 2/1/23 through 2/6/23 at 8:00 a.m.

On 2/6/23 records indicated that resident #2 is prescribed OS-Cal Extra D3 500mg/600 IU – take one tablet by mouth twice a day. . However, according to staff interviews, the home administered Calcium 60 + D 5mcg tablets on 2/1/23 through 2/6/23 at 8:00 a.m. and 8:00 p.m.

Plan of Correction

Directed (JW - 02/28/2023)

See attached .The administrator, after consulting with resident family on 02/13/23 the above medications, (all are over the counter provided by family), have been temporarily suspended, awaiting directions from PCP. The residents POA provided a note on 02/14/23 explaining the discrepancies. (see attached).) On 02/20/23 PCP discontinued all over the counter meds listed on residents MAR and issued an new order indicating resident may take any OTC's provided by the family. (see attachments) Going forward, direct care staff, (med trained) will enter on the MAR , the directions on the manufacture's labels for over the counter medications. Administrator will monitor all OTC entries to insure they match the manufactures recommendations.

Directed: The administrator will provide the specific date that the direct care staff, (med trained) will begin entering on the MAR, the directions on the manufacture's labels for over-the-counter medications and the specific date that the Administrator will begin monitoring all over-the-counter medication entries to insure they match the manufactures recommendations. J.W. 2/28/23

Directed Completion Date: 03/03/2023

Implemented (JW - 03/13/2023)

225a - Assessment 15 Days

6. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department’s assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

On 2/6/23 records indicated that resident #2 had a hospital bed with bed rails attached to both sides of the bed. However, the resident's initial assessment and support plan, dated [REDACTED], assess the resident's ability to transfer in/out of bed/chair and turning repositioning in bed/chair as B - needing prompting/cueing but did not indicate a hospital bed or bed rails and the need that this device addresses.

Plan of Correction

Directed (JW - 02/28/2023)

See attached. On 02/13/23 assist. administrator reviewed resident #2 RASP and noted there was not an order on hand for bed and rails to be used for repositioning . The bed and rails had been ordered by the family, prior to resident admission, [REDACTED] Assist. administrator called PCP on [REDACTED] and requested a written order for

225a - Assessment 15 Days (continued)

the bed rails which was faxed to the home. (see attached). On [REDACTED] administrator updated RASP to reflect the need for assistive bed rails for repositioning (see attached). Administrator will monitor any future assistive devices to insure orders are provided and appropriate entries are indicated on assessment and support documentation.

Directed: The administrator will provide the specific start date that the administrator will monitor any future assistive devices to ensure orders are provided and ensuring appropriate entries are indicated on assessment and support documentation. J.W. 2/28/23

Directed Completion Date: 03/03/2023

Implemented (JW - 03/13/2023)