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

May 12, 2023

[redacted], ADMINISTRATOR
BROOKE GROVE FOUNDATION INC
[redacted]

RE: REST ASSURED RESIDENTIAL LIVING CENTER
1137 SHIRLEY'S HOLLOW ROAD
MEYERSDALE, PA, 15552
LICENSE/COC#: 32132

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/29/2023 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**: *REST ASSURED RESIDENTIAL LIVING CENTER* **License #**: *32132* **License Expiration**: *12/07/2023*

**Address**: *1137 SHIRLEY'S HOLLOW ROAD, MEYERSDALE, PA 15552*

**County**: *SOMERSET* **Region**: *CENTRAL*

## Administrator

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

## Legal Entity

**Name**: *BROOKE GROVE FOUNDATION INC*

**Address**: [redacted]

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *04/08/2007* **Issued By**: *Labor & Industry*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

## Inspection Information

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

**Reason**: *Renewal, Complaint* **Exit Conference Date**: *03/29/2023*

## Inspection Dates and Department Representative

*03/29/2023 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *33* **Residents Served**: *24*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Entire* **Capacity**: *33* **Residents Served**: *24*

### Hospice

**Current Residents**: *5*

### Number of Residents Who:

**Receive Supplemental Security Income**: *2*

**Are 60 Years of Age or Older**: *24*

**Diagnosed with Mental Illness**: *3*

**Diagnosed with Intellectual Disability**: *0*

**Have Mobility Need**: *24*

**Have Physical Disability**: *0*

# Inspections / Reviews

### 03/29/2023 Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/22/2023*

### 04/26/2023 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *05/11/2023*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/03/2023*

## Inspections / Reviews *(continued)*

**04/27/2023 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *05/11/2023*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/04/2023*

**05/11/2023 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *05/11/2023*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/12/2023*

**05/12/2023 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *05/11/2023*

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

## 82c - Locking Poisonous Materials

**1. Requirements**

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

**Description of Violation**

*An 8 oz spray bottle of [redacted] Lotion with odor control, with a manufacturer's label indicating "contact poison control", was unlocked, unattended, and accessible on top of the toilet in the room of Resident #1. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.*

*A 44-count box of [redacted] with the manufacturer's label indicating "contact poison control", was unlocked, unattended, and accessible in the room of Resident #2. Not all the residents of the home, including Resident #2, have been assessed capable of recognizing and using poisons safely.*

**Plan of Correction** ***Accept ([redacted] - 04/27/2023)***

*During inspection 3/29/2023, Administration inspected all residents rooms and areas for "contact poison control" items and removed and placed in locked areas. Staff will be educated at this weeks staff meeting (04/04/2023) and on going on room inspections that detail the need to review the labels on items in resident accessible areas and take out the items that state "contact poison control." Families will be informed of the need to have all these items delivered to a staff member and not be left for accessibility for residents via a letter dated 4/12/2023. During walking rounds staff done daily will be expected to look for these items and remove. Management will do walk through daily and as listed on room inspections the need to identify if items are safe for residents and if meet unacceptable criteria, immediately they will be locked up.*

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented [redacted] - 05/12/2023)***

## 132f - Alternate Exit Routes

**2. Requirements**

2600.
132.f. Alternate exit routes shall be used during fire drills.

**Description of Violation**

*The Grand Room was the only exit route used during the fire drills held from 1/17/2022 to 2/16/2023.*

**Plan of Correction** ***Accept [redacted] - 04/27/2023)***

*Immediately post inspection on 3/29/2023 regulations were reviewed with Plant Operations and outlined the need to alternative exits monthly during fire drills. Fire drills will be done monthly using the alternative exit routes by staff and documentation of such will be monitored monthly by Administrator. Staff will be provided education done on 4/4/2023 and ongoing of the need to use alternative exits monthly and close monitoring by managers to ensure that follow through occurs.*

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented ([redacted] - 05/12/2023)***

## 183d - Prescription Current

**3. Requirements**

2600.

## 183d Prescription Current *(continued)*

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

**Description of Violation**

*On [redacted], [redacted] capsules, prescribed for Resident #3, were found in the home's medication cart; however, the medication was discontinued on [redacted]*

**Plan of Correction** ***Accept [redacted] - 04/27/2023)***

*Immediately the medication was discarded by LPN day of inspection. LPN/DON/Administrator will continue upon discontinuation of a medication (written order received) ensure that the medication is removed from medication cart and discarded by LPN or the Administrator. Daily the medication cart will be check by the LPN/DON/Medication Technicians to ensure medication that are ordered are available and mediations discontinuation will be ensured that they are removed and discarded per policy. LPN/Administrator initiated this on 3/30/2023.*

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented [redacted] - 05/12/2023)***

## 185a - Implement Storage Procedures

**4. 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 [redacted] blood sugar reading of [redacted], [redacted] blood sugar reading of [redacted] and [redacted] blood sugar reading of [redacted] on Resident #2's Medication Administration Record (MAR) were not found on the resident's glucometer.*

*On [redacted] at [redacted] the blood sugar reading recorded on Resident #2's MAR was [redacted]; however, a reading of [redacted] was found on the resident's glucometer.*
*On [redacted] at [redacted], the blood sugar reading recorded on Resident #2's MAR was [redacted]; however, a reading of [redacted] was found on the resident's glucometer.*
*On [redacted] at [redacted], the blood sugar reading recorded on Resident #2's MAR was [redacted] however, a reading of [redacted] was found on the resident's glucometer.*

*Various readings on the MAR of Resident #4 do not match the dates and times found in the resident's glucometer. These errors found on the glucometer include but are not limited to the following:*
*[redacted] at [redacted] and [redacted], [redacted] at [redacted], [redacted] and [redacted], [redacted] at [redacted], 6:01 am and 10:52 am. Many of these errors were readings taken outside of the scope of the prescribed times in the provider's order.*

**Plan of Correction** ***Accept [redacted] - 04/27/2023)***

*Immediate corrective action completed the LPN reviewed the blood glucometers for all residents and initiated a new system of compliance. Staff were education on the new quality improvement of reading glucometers, ensuring the time and date matched the time and date of taking the readings. All were trained accurate documentation of blood glucose and the importance of these numbers. Staff were provided an system of taking readings with accuracy, reporting and documentation via written tasks list and verbally explanation of steps. Staff are to ensure that all*

## *185a - Implement Storage Procedures (continued)*

*dates , times, numbers match with accuracy. LPN and CNA managers will continue the policy of glucometer checks weekly to ensure that staff are being comprehensive and accurate. Daily check data was educated to staff on 3/30/2023 and staff meeting on 4/4/2023.*
*Resident #4 Glucometer manufacturer was contacted and glucometer was discarded and new one purchased for Resident #4. This was completed on 4/3/23.*
*4/3/2023 New glucometer check system of checking the date, time and number was provided at staff meeting to staff and outlined details of necessity going forward. We are doing a three step procedure for glucometers: DATE, TIME, and NUMBER. Writing down numbers and double checking prior to entering them in the computer MAR.*

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented [redacted] - 05/12/2023)***

## 187c - Refusal of Medication

**5. Requirements**

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

**Description of Violation**

*On [redacted] at [redacted], Resident #3 refused to take a scheduled dose of [redacted]. The home did not notify the prescriber within 24 hours.*

**Plan of Correction** ***Accept ([redacted] - 04/27/2023)***

*LPN notified MD immediately after inspection. Policy and procedure regarding refusal of medication was reviewed with staff and they were educated on the need to inform LPN/Supervisors of the refusal immediately. The MD will be notified via fax the day of refusal. At 04/04/2023 staff meeting all staff were educated on refusal and the documentation of such, reporting procedure for such, and instructed to call LPN to obtain discontinuation prescription for continued refusals that occur from MD.*

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented ([redacted] - 05/12/2023)***

## 187d - Follow Prescriber's Orders

**6. Requirements**

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

**Description of Violation**

*Resident #2 is prescribed [redacted]. However, Resident #2 did not receive these medications on [redacted]. The medication administration record (MAR) was documented as "other" for these medications on this date.*

*Resident #3 is prescribed [redacted]. However, Resident #3 did not receive the Muscle Rub Cream on [redacted], with the only indication noted as "other". Resident #3 did not receive the Acetaminophen on [redacted] with the only indication noted as "other".*

187d - Follow Prescriber's Orders (continued)

*Resident #3 is prescribed a standing order for [redacted] three times daily. However, Resident #3 did not receive this medication on [redacted], nor [redacted], and there is no indication on the Medication Administration Record (MAR) as to why these were not given as prescribed.*

*Resident #4 is prescribed [redacted] and a four-time daily blood sugar check. However, Resident #4 did not receive any of these medications on [redacted], nor the blood sugar check at [redacted] nor [redacted], and there is no indication on the Medication Administration Record (MAR) as to why these were not given as prescribed.*

*Resident #3 is prescribed [redacted] one tablet every eight (8) hours as needed for [redacted] On [redacted], Resident #3 was given one dose at [redacted] and another dose at [redacted] (less than four hours apart).*

*Resident #4 is prescribed [redacted] on a sliding scale. On [redacted], the resident had a blood sugar reading of [redacted] According to the sliding scale, the resident should have received 6 units (251-300=6). The resident only received 4 units. On [redacted] the resident had a blood sugar reading of [redacted] According to the sliding scale, the resident should have received [redacted] (201-250=4). The resident only received [redacted]*

**Plan of Correction** ***Accept ([redacted] - 04/26/2023)***

*Immediately post inspection, the pharmacy provider was contacted to change the wording of QUICK MAR so that "other" was not an option. Staff were educated on the need to explain why medications were missed and provide a note this was done on 3/30/2023. Staff are being provided education the week of 4/16/2023 on SAFE MEDICATION PRACTICES to address the medication label, accuracy of double checking and reading the label and MAR with accuracy. training outlines reading the MAR, accuracy of orders, refusals, time frames, and documentation. Managers have placed the sliding scale in the MAR to ensure that resident receives the accurate dose of insulin according to blood glucose number as a double check system.*

**Licensee's Proposed Overall Completion Date:** *04/12/2023*

***Implemented ([redacted] - 05/12/2023)***

**7. Requirements**

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

**Description of Violation**

*Resident #2 is prescribed [redacted]. However, this medication was not administered to Resident #2 on [redacted] because the medication was not available in the home.*

*Resident #2 is prescribed [redacted]. However, this medication was not administered to Resident #2 on [redacted] because the medication was not available in the home.*

**Plan of Correction** ***Accept ([redacted] - 04/27/2023)***

*LPN / Administrator will be reviewing all new medication as the prescription arrives at the building. LPN will ensure that medication is available via the pharmacy coordination and ensure that it is available for the residents need. All new residents will have a comprehensive review of medications and ensure that all are available upon admission, LPN/DON is responsible for this task, she was educated on 3/30/2023 regulations and provided outline of details regarding prescriptions. Staff were education on 4/4/2023 regarding prescription for medications and the need to*

## 187d - Follow Prescriber's Orders (continued)

*comply with 5 rights per prescription. LPN given verbal guidance on admission and new prescription compliance by Administrator on* [redacted]

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented ([redacted] - 05/12/2023)***

## 227d - Support Plan Medical/Dental

**9. 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**

*The assessment for Resident #5, dated* [redacted]*, does not indicate that the resident has any type of mental health diagnosis or behavioral issues identified. However, records show that this resident has a history of* [redacted]*, and* [redacted]*. In addition, on* [redacted]*, resident was admitted involuntarily to the hospital for two false reports to 9-1-1 and state police, hallucinations of people committing inappropriate acts of sexual assault to* [redacted] *and others. None of these needs are identified on the resident's assessment, nor is there a plan as to how these needs will be met.*

*The assessment for Resident #2, dated* [redacted]*, does not indicate that the resident has* [redacted]*, even though* [redacted] *gets three times daily blood sugar checks, and daily insulin injections. The resident is also diagnosed with* [redacted] *disease as documented on thier assessment. There is no plan as to how these needs will be met.*

*Resident #3 has a diagnosis of* [redacted] *and sometimes utilizes adaptive eating equipment for his/her meals. The resident's RASP dated* [redacted] *makes no mention of Parkinson's Disease under the medical diagnoses nor does it address how these needs will be met. There is no mention of adaptive eating equipment usage under either the eating a drinking section, nor under the dietary needs section, in order to address the needs of the resident in regards to the Parkinson's Disease.*

**Plan of Correction** ***Accept ([redacted] - 04/27/2023)***

*LPN/Administrator will ensure that DME and RASP match so that all medical needs are met. LPN and Administrator completed chart audits on 3/30/2023 to inspect for compliance and scheduled audits once a month. LPN will ensure that any new diagnosis will be identified in RASP and how needs are met for that diagnosis are outlined. Chart audits will be conducted quarterly and when a resident goes to the hospital and returns a chart audit will be done. Resident #3 does not require any adaptive equipment at this time. LPN did add in RASP that when she appears to be have problems she will be offered adaptive spoons and forks at meals. Resident #5 closed chart was opened and diagnosis was added to RASP for compliance. Resident #2 RASP was amended on* [redacted] *with the additional diagnosis entered and care plan adjustment made by LPN*

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented ([redacted] - 05/12/2023)***

## 227g -Support Plan Signatures

**10. Requirements**

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

**Description of Violation**

*Resident #2 participated in the development of his/her support plan on 2/13/23. However, the resident did not sign the support plan, nor is there an indication that the resident was unable or refused to sign.*

**Plan of Correction** ***Accept ( - 04/27/2023)***

*RASP will be done in coordination with all members of family and the resident. Upon review the resident and their family members will sign off on the RASP to indicate that they have participated in the development. If the resident is unable to sign the RASP, the staff will ask for a mark that indicates their participation. Review of documentation and chart will ensure that this items is completed. Chart audits initiated on 3/30/2023 and will be done every 2 months.*
*Resident #3 signed RASP post inspection. on 3/29/2023.*

**Licensee's Proposed Overall Completion Date:** *04/26/2023*

***Implemented ( - 05/12/2023)***