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

July 21, 2023

[REDACTED], CEO
WEST HAVEN MANOR LP
153 GOODVIEW DRIVE
ATTN [REDACTED]
APOLLO, PA, 15613

RE: QUALITY LIFE SERVICES APOLLO
153 GOODVIEW DRIVE
APOLLO, PA, 15613
LICENSE/COC#: 44238

Dear Ms. [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/30/2023, 06/08/2023, 06/09/2023 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: *QUALITY LIFE SERVICES APOLLO* **Licen e #**: *44238* **Licen e Expiration**: *02/27/2024*

Address: *153 GOODVIEW DRIVE, APOLLO, PA 15613*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *WEST HAVEN MANOR LP*

Address: *153 GOODVIEW DRIVE, ATTN [redacted], APOLLO, PA, 15613*

Phone: *7247273102* **Email**: *arodriguez@qualitylifeservices.com*

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *06/06/2000* **I ued By**: *L&I*

Staffing Hours

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

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/09/2023*

Inspection Dates and Department Representative

05/30/2023 On Site [redacted]
06/08/2023 On Site [redacted]
06/09/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *11* **Have Physical Disability**: *1*

Inspections / Reviews

05/30/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/25/2023*

Inspections / Reviews *(continued)*

07/05/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/20/2023*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *07/12/2023*

07/13/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/20/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *07/20/2023*

07/21/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *07/20/2023*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] 23 at approximately [redacted] a.m. an allegation of neglect against resident #1 was documented by direct care staff person A involving direct care staff person B and direct care staff person C. However, the allegation of neglect was not immediately reported to the Department of Aging in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 – 10225.707) and 6 Pa. Code Sections 15.21 – 15.27 (relating to reporting suspected abuse) and was not reported to the Department of Aging until 6/8/23 at approximately 3:15 p.m.

Plan of Correction ***Directed ([redacted] - 07/13/2023)***

PCHA provided verbal education to staff member A regarding process of reporting suspected abuse.
PCHA educated staff on 7/3/23 on 2600.16c and educated on the importance that all incidents/allegations of abuse must be reported immediately to the administrator or wellness director PCHA or Wellness Director will report all ncidents to the department immediately
The Personal Care Administrator will interview 3 residents a week for 5 weeks to identify any care, neglect or abuse concerns. The interviews will begin the week of 7.3.2023 and conclude the week of 7.30.2023. The results of the nterviews will be kept by PCHA
Once POC is approved PCHA or Wellness director will audit all reportable incidents and conditions to ensure any reportable incidents and conditions are reported in accordance with regulation 2600.16c
Results of the audits will be reviewed and recorded in the monthly QAPI meeting
This education will be completed by 6.30.23. Documentation of the education will be kept

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all allegation of abuse to ensure any allegation of abuse is reported in accordance with Regulation 2600.15(a). 7/13/23 [redacted]

Directed Completion Date: *07/14/2023*

Implemented ([redacted] - 07/21/2023)

16c - Written Incident Report

2. 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

On [redacted] /23 at approximately [redacted] a.m. an allegation of neglect against resident #1 was documented by direct care staff person A involving direct care staff person B and direct care staff person C. However, the incident was not reported to the Department until 6/8/23.

Resident #1 ceased to breathe on date-of-death #1 at [redacted] However, the incident was not reported to the

16c - Written Incident Report (continued)

Department until 6/8/23.

Plan of Correction ***Accept (JK - 07/13/2023)***

Wellness director immediately suspended two employees B & C involved and remain on suspension since 5.28.2023.
Effective 7/7/23 employee B was terminated
PCHA provided verbal education to staff member A regarding process of reporting suspected abuse.
PCHA educated staff on 7/3/23 on 2600.16c education included the importance that all incidents/allegations of abuse must be investigated and reported to the administrator or wellness director immediately. PCHA or Wellness Director will report all incidents to the department immediately
The Personal Care Administrator will interview 3 residents a week for 5 weeks to identify any care, neglect or abuse concerns. The interviews will begin the week of 7.3.2023 and conclude the week of 7.30.2023. The results of the nterviews will be kept by PCHA
Once POC is approved PCHA or Wellness director will audit all reportable incidents and conditions to ensure any reportable incidents and conditions are reported in accordance with regulation 2600.16c
Results of the audits will be reviewed and recorded in the monthly QAPI meeting

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented [redacted] - 07/21/2023)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]/23 and [redacted]/23 from approximately [redacted] p.m. until [redacted] a.m., direct cart staff person C did not perform two-hour safety checks for all assigned residents dwelling in the front hallway. Resident #1, who passed away on date-of-death #1, was found at approximately [redacted] a.m. on the bedroom floor of resident room [redacted], naked on [redacted] right side with bruises on both legs and a skin tear on the right arm with dried blood on the floor and dresser.

Plan of Correction ***Accept [redacted] - 07/05/2023)***

Direct care staff person C and Direct care staff B person were immediately suspended pending abuse and neglect nvestigation.
Staff person C and B remain on suspension at this time.
PC Administrator will complete education with whole house staff on regulation 2600.42b. by July 21, 2023. A resident may not be neglected, intimidated, physically subjected to corporal punishment or disciplined in any way, verbally abused, mistreated)
This education will also include the importance of the two hour safety checks on all residents 24 hours a day 7 days a week. Documentation of the education will be kept.
Random audits via interviews will be conducted by the Personal Care Administrator with 3 residents a week for 5 weeks to ensure safety checks are happening. Any issues identified will be immediately investigated and addressed with the employee by the Personal Care Administrator. These audits/interviews will begin the week of 7.3.2023 and conclude 7.30.2023. Results of the audits/interviews will be reviewed and recorded in the monthly QAPI.

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 07/21/2023)

65a FS Orientation 1st Day

4. 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:

4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person D, hired /23, did not receive general orientation in general fire safety and emergency preparedness that including smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable and telephone use and notification of emergency services.

Plan of Correction ***Accept - 07/05/2023)***

PCHA immediately provided education/training with Staff person D on facility smoking safety procedures and facility smoking policy, including location. PCHA had staff person D sign off documenting completion on 06.30.23
HR Director will complete a whole house audit of current employee files to ensure all staff have been orientated on Smoking safety procedures and location of smoking areas. This audit will be completed by 7.07.2023.
Any employee found without completed education and training will be immediately provided by the Personal Care Administrator.
HR Director will complete a whole house audit of current employee files to ensure all staff have been orientated telephone and notifications of emergency services.
This audit will be completed by 7.07.23. Any employee found out of compliance will immediately be oriented by the Personal Care Administrator.
All new employees charts will be audited by the Personal Care Administrator for the next six months beginning 7.1.23 and concluding 12.31.23 to ensure 100% compliance and before they are allowed to work on the floor to ensure the charts and training are in compliance with regulation
2600.65a.
Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 07/21/2023)

65b Rights/Abuse 40 Hours

5. Requirements

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 the following:

2. Emergency medical plan.

Description of Violation

Direct care staff person D was hired , and as of 4/10/23 had worked an excess of forty-hours but did not

65b - Rights/Abuse 40 Hours (continued)

receive an orientation on the home's emergency medical plan.

Plan of Correction ***Accept (- 07/05/2023)***

On (6/30/23) PCHA completed education with Staff Member D regarding Emergency Medical Plan and had staff member D sign off on education/training.
HR Director will complete a whole house audit of all current employee files to ensure all staff have had orientation on the homes emergency medical plan. This audit will be completed by 7.07.23 Any employee found out of compliance will be immediately oriented according to regulation 2600.65b
All new employee charts will be audited by the personal care administrator for the next 6 months starting 7.1.23 and concluding 12.31.23 to ensure compliance of regulation 2600.65b Documentation of the audits will be kept. After 12/31/23 all employee chart will be reviewed bi-monthly to ensure compliance with all require documentation needed under Regulation 2600.65b
Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented - 07/21/2023)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person E, whose first day of work was /23, began providing unsupervised direct care services on /23. However, direct care staff E did not successfully complete and pass the Department-approved direct care training course and the competency test.

Direct care staff person F, whose first day of work was /23, began providing unsupervised direct care services on /23. However, direct care staff F did not successfully complete and pass the Department-approved direct care training course and the competency test.

Plan of Correction ***Accept (- 07/05/2023)***

On 6/8/23 PCHA had employee F Removed from schedules until completion DHS approved direct care training before returning to floor. This employee completed DHS Approved training on 6/14/23
PCHA immediately removed employee E from schedules and had employee E completed DHS approved direct care training on 6/14/23 (Employee no longer employed with company)
HR Director will complete a whole house audit of current employee files to ensure direct care staff has taken and completed the required DHS approved direct care training regulation 2600.65d courses and passed the comp. test This audit will be completed by 7.07.23.
Any employees found out of compliance with regulation 2600.65d will be removed from the schedule until they have the proper training completed.
Education will be provided to personal care staff by the NHA on the regulation 2600.65d "Successful completion and passing of DHS approved direct care training course and passing of comp. test". Documentation of the education

65d - Initial Direct Care Training (continued)

will be kept. Education will be completed by 7.14.23
All "new employee and current staff" charts will be audited by the personal care administrator monthly ensure compliance with regulation 2600.65d. Results of the audits will be kept.
Results of the audits will be reviewed and recorded in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 07/21/2023)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/30/23 at 4:00 p.m. the forty-gallon trash can in the home's kitchen was uncovered, unattended and filled with garbage to include cans of diced peaches, used parchment paper sheets, and various bits of plastic wrap with small amounts of food debris.

On 5/30/23 at 4:00 p.m. there was a ten-gallon garbage can that was uncovered, unattended, and attached to the red three shelf-kitchen cart in the home's kitchen that was approximately three-quarters full of garbage to include macaroni pasta salad, partially eaten chicken or fish patty sandwiches, food preparation gloves, and cans of generic soda.

Plan of Correction ***Accept (- 07/13/2023)***

.
On 5/30/23 staff immediately removed trash from the 40 gallon trash receptacle and place it in outside dumpster
On 5/30/23 staff immediately removed trash from the 40 gallon trash receptacle and place it in outside dumpster
Reeducation completed by PCHA on 6/23/23 with all kitchen staff reinforcing that at all times lids need to be on all trash cans to prevent infestation from rodents and insects.
This education will also include emphasis on kitchen area as identified as focus areas requiring inspection and cleaning more than once a day.
PCHA or designee will audit kitchen area 3 times a day for four (4) weeks and then twenty (20) per month for two (2) months using an audit tool to ensure that kitchen trash receptacles are clean and free of visible overflow. Any concerns identified will be brought to the housekeeping manager and PCHA.
Findings will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly
Education will be provided to all personal care staff including ancillary staff by the PCHA on the regulation 2600.85d that at all times lids need to on trash cans to prevent exposer to rodents and insects
Education should be completed by 7.07.23 and Documentation of the education will be kept.
Staff will audit daily starting 7/1/23 to ensure that lids are on all kitchen trash cans and not overflowing

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 07/21/2023)

100a - Exterior - Free of Hazards

8. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 5/30/23 at approximately 4:10 p.m. the concrete walkway to left of the joint pavilion where the water run-off grate meets the pavement, the concrete was deteriorated in two areas, the first measured two-inches wide by nine-inches long and was approximately three-quarters of an inch deep, and the second area formed the shape of a right triangle that measured six-inches long by four-inches at the widest point, and was approximately three-quarters of an inch deep. Both areas of deteriorated concrete were on an egress route and presented a tripping hazard for residents with walkers or an unsteady gait.

On 5/30/23 at approximately 4:10 p.m. the concrete walkway across from playground set located between the Personal Care Home and Skilled Nursing Facility had a fourteen-inch long by one-and-one-half-inch wide crack that was approximately one-inch deep, was located on an egress route, and presented a tripping hazard for residents with walkers or an unsteady gait.

On 5/30/23 at approximately 4:10 p.m. there was a concrete slab in the sidewalk next to the covered patio of the Personal Care Home that was deteriorated in two separate areas, the first measured approximately four-feet long by three-inches wide and approximately one-half-inch deep, and the second area was on the opposite side of the concrete slab and measured approximately six-feet long by four-inches at the widest point and approximately one-half-inch deep. Both areas of deteriorated concrete were on an egress route and presented a tripping hazard for residents with walkers or an unsteady gait.

On 5/30/23 at approximately 4:10 p.m. the concrete at the front entrance to Personal Care home in front of the three-seat bench was deteriorated in square pattern that measured approximately fourteen-inches at the longest point by approximately fifteen-inches at the widest point, and was approximately one-half inch deep, was located on an egress route, and presented a tripping hazard for residents with walkers or an unsteady gait.

Plan of Correction ***Accept ██ - 07/05/2023)***

Maintenance department repaired the areas on June 6, 2023 that were listed in LIS dated 6/15/23 to meet regulation 2600.100d.
All staff (including ancillary staff) will be provided educated by the personal care administrator on regulation 2600.100d the exterior of building and the building grounds or yard must be in good repair and free of hazards.
This education will be complete by 7.07.23. Documentation of the education will be kept.
Personal Care Administrator and Maintenance Supervisor will complete an initial audit of entire exterior of building to ensure that there was no other hazards and property is in good repair. This audit will be completed by 7.07.23.
The exterior of facility will be audited monthly by the Maintenance Director to ensure the exterior of the building and grounds remains in good repair. Monthly audits will be reviewed by PCHA.
Documentation of these rounds will be kept. Any areas of concern will be immediately addressed.
Findings of these audits/rounds will be reviewed and recorded in monthly QAOI meeting.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented ██ - 07/21/2023)

132a - Monthly Fire Drill

9. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of May 2023.

Plan of Correction ***Accept - 07/05/2023)***

On 5/30/23 documentation of May's unannounced fire drill was found and placed in the binder "Fire Drills". Per documentation fire drill occurred on 5/29/23 at 4:30 pm.
PCHA will continue monitor and audit fire drill process according to DHS Reg. 2600.132a to ensure compliance. Documentation of the education will be kept.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented - 07/21/2023)

142a - Secure Medical Care

10. Requirements

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

On 23 between the hours of p.m. and a.m. on /23, resident #1 experienced an unwitnessed fall was found naked on the floor of resident room on right side with multiple bruises on legs and a skin tear on right arm with dried blood on the floor and dresser. However, the home did not assist the resident in securing medical care related to the acute injuries suffered during the unwitnessed fall and did not document the resident's need for care or update the resident's assessment and support plan.

Plan of Correction ***Directed - 07/13/2023)***

Resident #1 has since passed and immediate correction could not be made to resident's assessment.
On 7/7/23 Staff was educated on the home's Fall Management Policy, Change of Condition Policy and Neuro Check Policy. All resident incidents/injuries will be documented in PCC Incident Reports Tab, family and physician will be notified
Residents will immediately be assessed by LPN/Wellness Director or by Med Tech to determine if additional or immediate care is needed
Neuro checks will be done at the time of assessment to determine if there was any change of condition ensure proper medical care is proper is provided.
PCC Dashboard to be updated regarding any resident that is transferred to local ED according to protocol. DHS reportable incident form will be transmitted within 24 hours to the Department.
Resident assessment Support Plan will be updated with any changes within 24 hours. Additionally staff will be in serviced/re-educated on the care needs of each individual resident to ensure that resident needs are being met.
New employees will be educated during General Orientation/Onboarding for all employees providing direct care, their requirement to report any changes in resident condition to shift supervisor within 24 hours or most preferably prior to the end of their shift. Changes will be reported immediately.

142a - Secure Medical Care (continued)

Documentation of the education will be kept.
Findings of these audits/rounds will be reviewed and recorded in monthly QAOI meeting.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all reports of resident injury, illness, or decline in a resident's health status to ensure medical care was obtained for the resident. 7/13/23

Directed Completion Date: *07/14/2023*

Implemented - 07/21/2023)

225a - Assessment 15 Days

11. 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

Resident #2, admitted , did not have an initial assessment completed.

Plan of Correction ***Accept (- 07/05/2023)***

Wellness Director immediately) completed an initial assessment with resident #2 and had resident #2 sign off on initial assessment. Initial assessment was placed in resident's hard chart.
Wellness Director and PCHA to complete review of all resident files to ensure that all resident has an initial assessment within 15 days of admission. Audits will continue monthly and cumulative quarterly audits from the date of onward of 7/1/23.
Education will be complete by PCHA to Wellness Director by 7.03.23 regarding that all "new admissions are required to have an initial assessment within 15 days of admission to facility. A new admission checklist will be implemented to capture the requirements under Reg. 2600.225a.
A complete audit of all resident files to ensure accuracy occurred on 6/25/2023 to ensure all residents on site have a completed initial assessment in accordance with DHS reg. 2600.225a. Cumulative quarterly audits to be completed onward from 6/25/23.
Documentation of the education will be kept.
Findings of these audits/rounds will be reviewed and recorded in monthly QAOI meeting

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented - 07/21/2023)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

The assessment dated for resident #1, who ceased to breath on date-of-death #1, was not updated to include

225c - Additional Assessment (continued)

[redacted] Hospice as a formal support and did not indicate the care and services provided by [redacted] Hospice which began [redacted] to include toileting, personal hygiene, bladder, and bowel management.

Plan of Correction ***Accept ([redacted] 07/05/2023)***

Resident #1 has since passed and immediate correction could not be made to resident's assessment.
PCHA and Wellness director to complete whole house audit of all residents who are currently receiving services from outside agencies (Home Health, Hospice, or Psych services, etc.). by 07.07.23. Once these residents are identified, the identified resident's RASP will be updated to include these formal supports and the services they are providing.
Education will be complete by PCHA to Wellness Director by 07.03.23 regarding updating resident's RASP to include all formal supports and services
Being provided.
Documentation of the education will be kept.
Findings of these audits/rounds will be reviewed and recorded in monthly QAOI meeting

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented ([redacted] - 07/21/2023)