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

November 20, 2023

[redacted], ADMINISTRATOR
JAI JALARAM CARE LP
2015 NORTH READING ROAD
DENVER, PA, 17517

RE: FAITHFUL LIVING
2015 NORTH READING ROAD
DENVER, PA, 17517
LICENSE/COC#: 32258

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/26/2023 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: *FAITHFUL LIVING* **License #**: *32258* **License Expiration**: *03/21/2024*

Address: *2015 NORTH READING ROAD, DENVER, PA 17517*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *JAI JALARAM CARE LP*

Address: *2015 NORTH READING ROAD, DENVER, PA, 17517*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/03/1985* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *67* **Waking Staff**: *50*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/26/2023*

Inspection Dates and Department Representative

09/26/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *66*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *11* **Are 60 Years of Age or Older**: *61*

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability**: *10*

Have Mobility Need: *1* **Have Physical Disability**: *2*

Inspections / Reviews

09/26/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/16/2023*

10/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/09/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/01/2023*

Inspections / Reviews *(continued)*

11/03/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/09/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/10/2023*

11/20/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/09/2023*

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

42b - Abuse

1. 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], while assisting Resident #1 from a wheelchair into a shower chair in preparation for [redacted] shower, staff person A intentionally kicked the left foot of Resident #1. Staff person A has a history of making disparaging remarks to and about Resident #1. Staff person A would disparage [redacted] due to [redacted] size, and say that [redacted] keeps [redacted] room too hot, and has refused to assist [redacted] from the toilet to [redacted] wheelchair after toileting.

Plan of Correction ***Accept ([redacted] - 11/03/2023)***

Once notified of abuse allegation on [redacted] the following was put in place:
Alleged abuser was suspended pending investigation by Administrator and Director of Wellness on 9/5/23.
Resident alleging abuse was medically checked with no sign of injury by care team on 9/5/23.
Full investigation was conducted which entailed resident and staff interviews pertaining to incident beginning on 9/5/23 and ending on 9/6/23 by Director of Wellness and Administrator.
Accused employee was terminated on 9/15/23.
All reported to DHS on 9/6/23, but reported to AAA via phone reporting system on 9/5/23.
All residents were spoken to ensure issue was not widespread and that all residents are fully educated on what abuse is and who to report it to. This occurred on 9/5/23 and 9/6/23 during interviews with Director of Wellness and Administrator.
Abuse policy reviewed and all team members received a full reeducation on all levels of abuse and proper protocols on 10/24/23 by Regional Director of Operations.
A QA system has been put in place which includes randomly interviewing 5 residents per month to ensure they are happy and receive care in a kind, courteous, gentle, and appropriate manner, and also ensuring they are again aware of who to report any form of abuse or mistreatment to. This will begin on November 1st, and will not have an end date. These interviews will be conducted by the Director of Wellness and documentation will be kept in the Director of Wellness's office in a binder for reference. Documentation will be kept for a year, or until resident discharges from Faithful living, whichever is sooner.
Administrator responsible for continued compliance with plan of correction.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented ([redacted] - 11/13/2023)

144c1 - Smoking Area Guidelines

2. 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:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

144c1 - Smoking Area Guidelines *(continued)*

Description of Violation

The home permits smoking in the designated smoking areas located at the two ends of the home outside, in a smoking "patio" and a smoking "shack". There are signs posted outside the main entrance stating "No Smoking In This Area". However, upon approach to the entrance of the home on 9/26/23, at approximately 9:05 am, seven (7) Winston brand cigarette butts were observed – located in the gravel in the front of the home near the main entrance. In addition, there are a few other cigarette butts of various varieties on the asphalt under the front portico area.

Repeat Violation - 5/10/23 and 1/12/23

Plan of Correction ***Accept (- 11/03/2023)***

All smoking paraphernalia was immediately removed, and a full facility perimeter walkthrough was completed on 9/26/23 upon notification during inspection by Maintenance Director. Resident responsible was already issued a 30-day notice at time of findings by Administrator.
A full review and assessment was completed of all smokers to ensure they are all physically capable and understand our policy and where smoking areas are located by Administrator on 9/27/23.
All team members were educated on fire safety and the importance of ensuring smoking policy is being followed and any infractions are addressed and reported immediately to Administrator. This training was completed by Regional Director of Operations on 10/24/23.
The following QA system has been implemented effective 11/1/23:
Maintenance is to inspect all exit ways and smoking areas twice per day to ensure all is safe and in compliance. Any findings will be immediately taken care of and reported to the Administrator.
A Shift-to-shift checklist has been created and implemented which include inspecting exit ways ensuring all is in compliance and safe during care team shift to shift rounds. All findings are immediately reported to Director of Wellness to be discussed at daily standup meeting with management team. This was implemented on 11/1/23 by the Regional Director of Operations and Director of Wellness.
A smoking Assessment form has been implemented to assess all smoker upon admission, change in condition, and annually to ensure all are able to smoke safely. These assessments will be done by the Director of Wellness. Records of this documentation will be kept in the resident medical charts.
A Smoking contract has been implemented for all smokers upon admission to ensure all are educated on spoking policy and document as such. This contract will be signed by the Administrator/designee and will be kept in the residents admission record.
A Smoking list has been created to ensure team is keeping track of all active smokers on a continuous basis. This list is kept in the med room, as well as the front office. The Assistant Administrator is responsible for updating this list and distributing to the appropriate locations as a new smoker is added.
Administration will be responsible to ensure continued compliance with this plan of correction.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented (- 11/13/2023)

182c - Medication Administration

3. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

On [redacted] at approximately [redacted], during a room inspection of Resident #2, there was a small plastic medicine

182c Medication Administration (continued)

cup containing three (3) pills sitting on [redacted] nightstand beside the chair he was sitting in. While speaking with the resident, [redacted] indicated that they are [redacted] morning meds that [redacted] had just not taken yet. When asked if staff watch [redacted] take [redacted] meds, [redacted] states "sometimes, but it depends who it is". This resident has not been assessed to self administer [redacted] own medications.

On [redacted] during lunch time, an empty plastic cup and and an empty paper medication cup were observed on the table of Resident #3. When asked, the resident stated that the plastic cup held [redacted] "chest congestion liquid" (there was still a small amount remaining which smelled like cough medicine) for [redacted] r cough, and the paper cup held [redacted] "lunch pills". Resident #3 stated that Staff Member B gave it to [redacted] with [redacted] lunch.[redacted] stated that the staff person did not watch [redacted] ingest the medication.

Plan of Correction ***Accept [redacted] - 11/03/2023)***

The following immediate action was taken upon notification of occurrences.
1. Disciplinary Action (Coachable Moment) was completed with employee MW about proper Medication Administration practices on 9/27/23.
2. Our Medication Administration policy was reviewed, and all applicable staff were educated by Director of Wellness on medication administration as well as what to do if medication is found in resident room on 9/27/23.
3. All Medication staff were also educated by Director of Wellness on proper medication administration practices, including the proper completion of a medication administration which includes ensuring all medications have been ingested before the med tech leaves the resident on 9/27/23.
4. Monthly med tech meetings will be implemented beginning on 10/1/23 to review proper medication administration policies and procedures to ensure ongoing compliance. These will continue monthly and will be ongoing.
5. DOW and Administrator will be responsible to ensure compliance in this area by keeping records of all training, as well as completing bi weekly med pass check ins with med techs, as well as med cart audits to ensure all proper medication practices are being followed. Record of these audits will be kept by Director of Wellness.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented ([redacted] - 11/13/2023)

183a - Original Containers and Injections

4. 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

On [redacted] at approximately [redacted], there was a translucent orange pill bottle with no label containing what was identified by the resident as [redacted] on the bureau behind the television in the room of Resident # 2.

Plan of Correction ***Accept [redacted] - 11/03/2023)***

1. The following immediate action was taken upon notification of occurrences.
Identified expired and unlabeled medication for residents and Director of Wellness ensured their removal from

183a Original Containers and Injections (continued)

the rooms on 9/25/23 upon notification during inspection.
2. A full audit of all resident rooms has been completed by the Director of Wellness and found to be in compliance 9/25/23 and 9/26/23.
3. Our Medication Administration policy was reviewed, and all applicable staff were educated by Director of Wellness on medication administration and all medication staff were also educated on checking expiration dates and proper medication storage and labeling on 10/3/23. Record of this training can be found in POC binder.
4. A Quality Assurance system has been put in place to ensure continued compliance which includes the following:
Each Medication Technician for Morning and Evening Shifts will be required to check resident rooms for each other as a double check system to ensure all is in compliance with medication in resident rooms daily. This will be done daily for one month, and then weekly for 3 months, ending in December. Any findings will be immediately reported to the Administrator or Director of Wellness.
A shift to shift checklist has been implemented which includes a general check of Medication and status and conduct a walkthrough of the community together. This will begin on 10/18/23 and continue daily. There will be no end date.
Director of Wellness will conduct a monthly review of all residents that are allowed to self administer to ensure they are safe for the next 3 months, beginning in October and ending in December.
Leadership team will conduct a full community walkthrough/audit monthly of all resident rooms and medication room ensuring compliance. This will remain in place for 3 months beginning in October and ending in December.
5. DOW and Administrator will be responsible to ensure compliance in this area.

Proposed Overall Completion Date: 11/01/2023

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented [redacted] - 11/19/2023)

183b - Meds and Syringes Locked

5. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted] at approximately [redacted] there was a small plastic medicine cup containing three (3) pills sitting on the nightstand in the room of Resident #2 which was unlocked, unattended, and accessible.

There was also a bottle of OTC [redacted] and an unlabeled bottle of what was identified as [redacted] on the bureau behind the television in the room of Resident #2 which were unlocked, unattended, and accessible.

On 9/26/23 at approximately 9:35 AM, there were the following medications found in an unlocked drawer beside a lockbox in the shared room of Resident #4. Although Resident #4 is assessed to self administer medications, [redacted] roommate is not. These medications were found unlocked, unattended and accessible:
Two (2) bottles of [redacted]
Two (2) bottles of
One (1) bottle of

183b - Meds and Syringes Locked (continued)

Repeat Violation - 5/10/23 and 1/12/23

Plan of Correction ***Accept (- 11/03/2023)***

1. The following immediate action was taken upon notification of occurrences.
- Identified expired and unlabeled medication for residents and Director of Wellness ensured their removal from the rooms immediately upon notification on 9/25/23.
2. A full audit of all resident rooms has been completed by Director of Wellness and found to be in compliance on 9/25/23, and 9/26/23.
3. Our Medication Administration policy was reviewed, and all applicable staff were educated by Director of Wellness on medication administration and all medication staff were also educated on checking expiration dates and proper medication storage and labeling on 10/3/23. Record of this training can be found in POC binder in Administrator office.
4. A Quality Assurance system has been put in place to ensure continued compliance which includes the following:
- Each Medication Technician for Morning and Evening Shifts will be required to check resident rooms for each other as a double check system to ensure all is in compliance with medication in resident rooms daily. This will be done daily for one month, and then weekly for 3 months, ending in December. Any findings will be immediately reported to the Administrator or Director of Wellness.
- A shift-to-shift checklist has been implemented which includes a general check of Medication and status and conduct a walkthrough of the community together. This will begin on 10/18/23 and continue daily. There will be no end date.
- Director of Wellness will conduct a monthly review of all residents that are allowed to self-administer to ensure they are safe for the next 3 months, beginning in October and ending in December.
- Leadership team will conduct a full community walkthrough/audit monthly of all resident rooms and medication room ensuring compliance. This will remain in place for 3 months beginning in October and ending in December.
5. DOW and Administrator will be responsible to ensure compliance in this area.

Proposed Overall Completion Date: 11/01/2023

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented - 11/19/2023)

183f - Discontinued Medications

6. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On at approximately , the following medications were found in an unlocked drawer beside a lockbox in the shared room of Resident #4. All of the following medications are currently expired:

Two (2) bottles of
Two (2) bottles of
One (1) bottle of

183f Discontinued Medications *(continued)*

Plan of Correction ***Accept ([redacted] - 11/03/2023)***

1. The following immediate action was taken upon notification of occurrences.
Identified expired and unlabeled medication for residents and Director of Wellness ensured their removal from the room immediately upon notification on 9/25/23.
2. A full audit of all resident rooms has been completed by Director of Wellness and found to be in compliance on 9/25/23, and 9/26/23.
3. Our Medication Administration policy was reviewed, and all applicable staff were educated by Director of Wellness on medication administration and all medication staff were also educated on checking expiration dates and proper medication storage and labeling on 10/3/23. Record of this training can be found in POC binder in Administrator office.
4. A Quality Assurance system has been put in place to ensure continued compliance which includes the following:
Each Medication Technician for Morning and Evening Shifts will be required to check resident rooms for each other as a double check system to ensure all is in compliance with medication in resident rooms daily. This will be done daily for one month, and then weekly for 3 months, ending in December. Any findings will be immediately reported to the Administrator or Director of Wellness.
A shift to shift checklist has been implemented which includes a general check of Medication and status and conduct a walkthrough of the community together. This will begin on 10/18/23 and continue daily. There will be no end date.
Director of Wellness will conduct a monthly review of all residents that are allowed to self administer to ensure they are safe for the next 3 months, beginning in October and ending in December.
Leadership team will conduct a full community walkthrough/audit monthly of all resident rooms and medication room ensuring compliance. This will remain in place for 3 months beginning in October and ending in December.
5. DOW and Administrator will be responsible to ensure compliance in this area.

Proposed Overall Completion Date: 11/01/2023

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented ([redacted] - 11/19/2023)