

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

February 7, 2024

[REDACTED], OWNER
HIGHLAND PARK SENIOR LIVING LLC
874 SCHECHTER DRIVE
WILKES-BARRE TOWNSHI, PA, 18702

RE: HIGHLAND PARK SENIOR LIVING
874 SCHECHTER DRIVE
WILKES-BARRE TOWNSHI, PA, 18702
LICENSE/COC#: 22630

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/28/2023, 11/29/2023 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: HIGHLAND PARK SENIOR LIVING License #: 22630 License Expiration: 10/05/2024
 Address: 874 SCHECHTER DRIVE, WILKES BARRE TOWNSHI, PA 18702
 County: LUZERNE Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED]

Legal Entity

Name: HIGHLAND PARK SENIOR LIVING LLC
 Address: 874 SCHECHTER DRIVE, WILKES-BARRE TOWNSHI, PA, 18702
 Phone: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 03/01/2018 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 133 Waking Staff: 100

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 11/29/2023

Inspection Dates and Department Representative

11/28/2023 - On-Site [REDACTED]
 11/29/2023 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 160 Residents Served: 101

Secured Dementia Care Unit
 In Home: Yes Area: n/a Capacity: 24 Residents Served: 23

Hospice
 Current Residents: 4

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 101
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 32 Have Physical Disability: 0

Inspections / Reviews

11/28/2023 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/15/2023

12/18/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 01/10/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/22/2023

Inspections / Reviews *(continued)*

01/08/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/10/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 01/10/2024

02/07/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/10/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home did not have the License Inspection Summary (LIS) report dated 8/31/22 posted in a conspicuous manner in the home. The LIS reports were stored in a folder that wasn't visible to the public.

Plan of Correction

Accept (█) - 01/05/2024)

The bin that holds the past inspections has been labeled as per inspectors request to make the inspection bin more visible on the day of inspection 11/28/2023. █, Administrator will monitor bin monthly to ensure label on the front of the bin remains intact and inspection binders are visible to visitors, residents and staff.

Licensee's Proposed Overall Completion Date: 12/18/2023

Implemented (█) - 01/31/2024)

15a - Resident Abuse Report

2. 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

During a resident interview resident #1 reported that staff person A bumped a wheel chair into their arm in the dining area. When resident #1 yelled at staff person A, Staff person A yelled back at resident #1 admonishing them for leaving their walker at the table and for speaking to staff person A in that manner. Resident #1 complained to the administrator about staff person A. The home did not report the incident to the local area agency on aging as required.

Plan of Correction

Directed (█) - 01/08/2024)

Moving forward as of 12/19/23 █, Administrator will immediate report suspected abuse of a resident as required so that the local area agency on aging can investigate in accordance with the Older Adult Protective Services Act and requirements regarding restrictions on staff persons.

Within 7 days of receipt of this directed plan of correction.

All staff, including the administrator, will receive training in abuse reporting and prevention. In the future, the administrator will ensure that all suspected abuse is reported in accordance with the Older Adults Protective Services Act.

Directed Completion Date: 01/15/2024

Implemented (█) - 01/31/2024)

16c - Written Incident Report

3. 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

During a resident interview resident #1 reported that staff person A bumped a wheelchair into their arm in the dining area. When resident #1 yelled at staff person A, Staff person A yelled back at resident #1 admonishing them for leaving their walker at the table and for speaking to staff person A in that manner. Resident #1 complained to the administrator about staff person A. The home did not report the incident to the department’s regional office as required.

Plan of Correction

Directed (█ - 01/08/2024)

Moving forward as of 12/19/23 █, Administrator will immediate complete a written report and report the incident to the Departments personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the department.

Within 7 days of receipt of this directed plan of correction.

All staff, including the administrator, will receive training in incidents reporting required to be reported by 2600.16a with all staff. The administrator will ensure that all required incidents will be reported to the Department within 24 hours of the incident. Documentation of training shall be maintained by the home and made available to the department upon request.

Directed Completion Date: 01/15/2024

Implemented █ - 01/31/2024)

42c - Treatment of Residents

4. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

During a resident interview resident #1 reported that staff person A bumped a wheelchair into their arm in the dining area. When resident #1 yelled at staff person A, Staff person A yelled back at resident #1 admonishing them for leaving their walker at the table and for speaking to staff person A in that manner. Resident #1 complained to the administrator about staff person A.

Plan of Correction

Directed █ - 01/08/2024)

Glass of milk and butter were utilized the same day 11/28/23.

Moving forward █, Director of Dining will complete daily audits of refrigerator in cafe and in Bridges to ensure labeling of items with name and date.

Proposed Overall Completion Date: 12/20/2023

Within 7 days of receipt of this directed plan of correction.

42c - Treatment of Residents (continued)

All staff, including the administrator, will receive training in resident rights. Documentation of training shall be maintained by the home and made available to the department upon request. Residents will be treated with dignity and respect. The administrator will monitor for ongoing compliance.

Directed Completion Date: 01/15/2024

Implemented (████) - 02/07/2024)

65g - Annual Training Content

5. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- 1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

The home did not have documentation that staff persons B, C, and D attended a fire safety training conducted by a fire safety expert for the 2022 training year.

Plan of Correction

Directed (████) - 01/08/2024)

Moving forward ██████████, Administrator has completed training for fire safety expert 12/13/23 to continuously train staff monthly during every fire drill in order for all staff to complete the training due to all 80 staff members inability to attend at one time. Moving forward ██████████, Administrator will have staff sign off on individual sign in sheets monthly during each fire drill and the yearly training by ██████████ or one of ██████████ employees.

Proposed Overall Completion Date: 12/20/2023

Within 7 days of receipt of this directed plan of correction.

The administrator will audit all staff training for the required training topics. The administrator received training on 12/13/2023 by a fire safety expert to conduct fire safety training for all staff of the home. The administrator will train staff member's B, C, and D in fire safety training. Administrator will have staff sign off on individual sign in sheets monthly during each fire drill and the yearly training by a fire safety expert. The administrator will monitor for ongoing compliance.

Directed Completion Date: 01/15/2024

Implemented (████) - 01/31/2024)

96b - First Aid Location

6. Requirements

2600.

96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

During the physical site inspection staff in the memory care unit were unable to immediately locate the first aid kit. During the medication cart audit staff in the 1st floor medication room also were unable to immediately find the

96b - First Aid Location (continued)

location of the nearest first aid kit.

Plan of Correction

Accept (█) - 01/08/2024)

Retraining has been completed 12/11/23 with █, Administrator to re-educate staff to the locations of first aid kits. As █, Administrator ensures yearly that they meet compliance, staff will be reintroduced to areas again.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented (█) - 01/31/2024)

103e - Left Overs

7. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

A glass of milk with plastic wrap over it was found in the refrigerator in the memory care unit kitchenette with no date marked on it. A container of butter found on the counter in the same kitchenette also had no date labeled on the container.

Plan of Correction

Directed (█) - 01/08/2024)

Glass of milk and butter were utilized the same day 11/28/23.

Moving forward Wayland Davis, Director of Dining will complete daily audits of refrigerator in cafe and in Bridges to ensure labeling of items with name and date.

Proposed Overall Completion Date: 12/20/2023

Within 7 days of receipt of this directed plan of correction.

The home's Director of Dining will complete daily audits of all refrigerators for leftover food that shall be labeled and dated. The administrator will complete monthly audits of the home's refrigerators for ongoing compliance.

Directed Completion Date: 01/15/2024

Implemented (█) - 01/31/2024)

103f - Refrigerator/Freezer Temps

8. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The ice cream freezer located in the main dining room contained several tubs of ice cream and had a temperature of 40° F according to the thermostat. Also, a tub of butter was found stored on the counter in the memory care kitchenette area.

103f Refrigerator/Freezer Temps (continued)

Plan of Correction

Accept (█ - 01/08/2024)

█, Administrator moved the thermometer back into correct position further down into freezer 11/28/23 which brought it back to read the correct temperature. █, Activities Director will monitor location of thermometer daily and temperature of freezer daily to ensure proper reading of temperature.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented (█ - 01/31/2024)

121a - Unobstructed Egress

9. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The exit door located to the rear of the main dining room was partially blocked by a Christmas tree that was placed near the door.

Plan of Correction

Accept (█ - 01/08/2024)

█, Activities Director moved the Christmas tree on 11/28/23 away from door to area that would not obstruct egress route from dining room to outside courtyard in case of an emergency. █, Activities Director will monitor weekly until Christmas tree is removed after the holidays that it stays in the approved area.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented (█ - 01/31/2024)

125a - Combustible Storage

10. Requirements

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A planter with dirt and dried leaves in it located next to the door leading to the memory care courtyard contained numerous extinguished cigarette butts.

Plan of Correction

Accept (█ - 01/08/2024)

█ Maintenance Supervisor removed planter from memory care courtyard and disposed of properly. █ Maintenance Supervisor will continue to monitor outdoors monthly to ensure compliance and that combustible and flammable materials will not be located near heat sources or hot water heaters.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented (█ - 01/31/2024)

131f - Fire Extinguisher Inspection

11. Requirements

2600.

131f Fire Extinguisher Inspection (continued)

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher located to the left of the hallway wing nearest the exit door on the left side of the home did not have an inspection tag attached to it during the initial walk through.

Plan of Correction

Accept () - 01/08/2024)

The tag on the fire extinguisher located to the left of the hallway wing nearest the exit door on the left side of the home was replaced 11/29/23. Moving forward Maintenance Supervisor, [redacted] will do monthly audits of fire extinguishers and will ensure that if tag becomes displaced to ensure that it is replaced immediately.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented () - 02/07/2024)

132e - Fire Drill Sleeping Hours

12. Requirements

2600.

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

Description of Violation

The home conducted a sleeping hour fire drill on 6/17/22 at 12:10am and then did not conduct another sleeping hour fire drill again until 10 months later on 4/12/23 at 6:10am. The home did not conduct another sleeping hour fire drill six months later in October 2023 as required.

Plan of Correction

Accept () - 01/08/2024)

[redacted], Administrator has taken the fire train the trainer course 12/13/23. [redacted], Administrator has mapped out fire drills for 2024 and will ensure that they overnight drills will be conducted every 6 months to ensure compliance.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented () - 01/31/2024)

141a 1-10 Medical Evaluation Information

13. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

141a 1-10 Medical Evaluation Information (continued)

Description of Violation

The Documentation of Medical Evaluation (DME) forms dated [redacted] and [redacted] for resident #2 were both missing the resident's weight.

Plan of Correction

Directed ([redacted] - 01/08/2024)

[redacted], Director of Wellness will conduct monthly chart reviews to ensure DMEs are in compliance. If a resident is unable to obtain weight due to non weight bearing Director of Wellness, [redacted] will obtain order from doctor.

Proposed Overall Completion Date: 12/20/2023

Within 7 days of receipt of this directed plan of correction.

The administrator will ensure that physicians perform all of the required actions during medical evaluations. The actions will be documented on the Department's medical evaluation form. The home's administrator will audit all resident's medical evaluations. The administrator will have resident's #2 medical evaluation completed. The administrator will monitor for ongoing compliance.

Directed Completion Date: 01/15/2024

Implemented ([redacted] - 01/31/2024)

144c1 - Smoking Area Guidelines

14. 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.

Description of Violation

Next to the door leading into the memory care unit courtyard a planter was observed with numerous extinguished cigarette butts. The designated smoking area is across the patio where an ashtray receptacle was placed.

Plan of Correction

Accept ([redacted] - 12/18/2023)

Moving forward memory care staff will monitor any residents smoking to ensure proper use of ashtray receptacle. Planter has been removed also. Director of Wellness will monitor monthly for compliance.

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

Implemented ([redacted] - 01/31/2024)

162c - Menus Posted

15. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted (continued)

Description of Violation

The home had only the current week's menus posted in the home.

Plan of Correction

Accept [redacted] 12/18/2023)

Moving forward Director of Dining will ensure that the menu will be posted for one week in advance in a conspicuous and public place in the home. Administrator will monitor monthly for compliance.

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

Implemented [redacted] - 01/31/2024)

184a - Resident's Meds Labeled

16. Requirements

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 #3 has an order for [redacted] to be held if the systolic blood pressure (SBP) is less than [redacted] or the diastolic blood pressure (DBP) is less than [redacted]. The blister pack for the medication did not include the parameter.

Plan of Correction

Accept [redacted] - 01/08/2024)

Training was completed on 12/8/23 with [redacted], Director of Wellness with med techs to ensure proper documentation, parameters with medications are labeled properly and documented properly in MARs. Moving forward [redacted], Director of Wellness will monitor compliance during monthly cart/ MAR audits.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented [redacted] - 01/31/2024)

187d - Follow Prescriber's Orders

17. Requirements

2600.

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

Description of Violation

Resident #4 has an order for insulin to be administered on a sliding scale [redacted] times daily. On the following dates and times the incorrect insulin units were administered:

[redacted] at [redacted] the blood glucose reading of [redacted] required [redacted] of insulin, [redacted] units were administered.

[redacted] at [redacted] the blood glucose reading of [redacted] required [redacted] units of insulin; [redacted] units were administered.

[redacted] at [redacted] the blood glucose reading of [redacted] required [redacted] units of insulin, [redacted] were administered.

Resident #3 has an order for [redacted] at [redacted] to be held if the SBP is less than [redacted] or the DBP is less than [redacted]

On the following dates the resident's DBP was less than [redacted] and the medication was not withheld as per the physician's orders:

[redacted]

Resident #5 has an order for [redacted] at noon to be held if the SBP is less than 120 or the DBP is less than 70.

On [redacted] at noon the DBP was [redacted] on both dates and the medication was not withheld per the physician's orders.

187d Follow Prescriber's Orders (continued)

Plan of Correction

Accept (█ - 01/08/2024)

Training was completed on 12/8/23 with █, Director of Wellness with med techs to ensure proper documentation, parameters with medications are labeled properly and documented properly in MARs. Moving forward █, Director of Wellness will monitor compliance during monthly cart/ MAR audits.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented (█ - 02/07/2024)

227g -Support Plan Signatures

18. Requirements

2600.

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

Description of Violation

The support plan dated █ for resident #6 was not signed by the person completing the support plan.

Plan of Correction

Accept (█ - 01/08/2024)

12/6/23 retraining was completed by █, administrator to ensure that moving forward support plans will be completed in allotted time frame to ensure compliance and to be signed by designated person that completed it. Director of Wellness, █, to ensure compliance during monthly chart audits.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented (█ - 01/31/2024)

231b - Medical Evaluation

19. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #6 was admitted to the home's memory care unit on █. The DME was not completed until █.

Plan of Correction

Accept (█ - 01/08/2024)

12/6/23 retraining was completed by █, administrator to ensure that moving forward medical evaluations will be completed in allotted time frame to ensure compliance. Director of Wellness, █, to ensure compliance during monthly chart audits.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented (█ - 01/31/2024)

234a - Admission Support Plan

20. Requirements

234a - Admission Support Plan (continued)

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #6 was admitted to the home's memory care unit on [REDACTED] The Support plan was not completed until [REDACTED]

Plan of Correction

Accept [REDACTED] - 01/08/2024)

[REDACTED] Retraining was completed with staff regarding DMEs and RASPs to meet compliance. [REDACTED], Director of Wellness will monitor dates of support plans to ensure that they are completed in allotted time frame to ensure compliance.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented [REDACTED] - 01/31/2024)