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

December 4, 2023

[redacted]
ALWAYS ON CARE LLC
[redacted]

RE: ALWAYS ON CARE
600 NORTH LAUREL STREET
HAZELTON, PA, 18201
LICENSE/COC#: 23006

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/07/2023 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: *ALWAYS ON CARE* **License #:** *23006* **License Expiration:** *06/03/2024*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/22/2010* **Issued By:** *PALI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *18* **Waking Staff:** *14*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *09/07/2023*

Inspection Dates and Department Representative

09/07/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served:** *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *11* **Are 60 Years of Age or Older:** *12*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability:** [redacted]

Have Mobility Need: *0* **Have Physical Disability:** [redacted]

Inspections / Reviews

09/07/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/07/2023*

10/12/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/25/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/17/2023*

Inspections / Reviews *(continued)*

10/18/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/25/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/25/2023*

12/04/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/25/2023*

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 most recent LIS renewal from 6/22/2022 was not posted in the home at the time of inspection.
Repeat violation 6/22/2022.

Plan of Correction ***Accept [redacted] - 10/18/2023)***

The Administrator is responsible for fixing the problem, and the administrator fixed the problem by printing and hanging the LIS renewal from 06/22/2022 on the bulletin board in the main hallway on 09/10/2023.

To ensure the violation will not occur again, the Administrator will print a copy of the future final license inspection summary within 24 hours of receipt and hang it on the bulletin board. The Administrator will do a physical check every two weeks to ensure the final license inspection summary remains posted on the bulletin board in the main hallway.

Licensee's Proposed Overall Completion Date: *10/18/2023*

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

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The contract dated [redacted] for Resident 1 does not include their signature.
Repeat violation 6/22/2022.

Plan of Correction ***Accept [redacted] - 10/12/2023)***

Administrator/Assistant Administrator reviewed the regulations for home contracts 2600 (25b) and will ensure the Administrator/designee and each resident signs the contract per regulation policy which requires the resident to sign the home contract with the payer if different from the resident and with a designated person.
The contract dated [redacted] for Resident 1 was signed by their court appointed legal guardian within 72 hours of admission on [redacted]. The contract was reviewed with the resident and they signed on [redacted].

Licensee's Proposed Overall Completion Date: *10/07/2023*

Implemented [redacted] - 11/13/2023)

54a - Direct Care Staff

3. Requirements

2600.

54a - Direct Care Staff *(continued)*

54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

The home does not have verification that Direct Care Staff Member A has a high school diploma, or GED.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

Administrator will ensure each new direct care staff submits proof of education (at the minimum, a high school diploma/GED) or active registry on the PA nurse aide registry prior to being placed on the schedule.
Staff Member A submitted [redacted] HS GED on 09/15/2023 and it has been placed in [redacted] personnel file.

Licensee's Proposed Overall Completion Date: *10/07/2023*

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

65b - Rights/Abuse 40 Hours

4. 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:
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff member B was hired [redacted] but there is no verification that they received orientation in Older Adult Protective Services Act within their first 40 hours working.

Plan of Correction ***Accept [redacted] - 10/12/2023)***

All new hires are trained in the Older Adult Protective Services Act within 40 scheduled working hours and annually each calendar year.
Staff person B was hired on [redacted] and completed the training on [redacted] in the Older Adult Protective Services Act however, the training was not listed on the log in error. Administrator reviewed all training logs to make sure the correct ones were being used to document all trainings.

Licensee's Proposed Overall Completion Date: *10/07/2023*

Implemented [redacted] - 11/13/2023)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

There was a strong odor of urine coming from the room of Resident 2.
Resident 3 had [redacted] checked in error on the [redacted] of Resident 1 on [redacted].

Plan of Correction ***Accept ([redacted] - 10/18/2023)***

There was a strong odor of urine coming from the room of Resident 2. Prior to the resident moving into the PCH

85a - Sanitary Conditions (continued)

the room was renovated and all new accessories were placed into the room including: new furniture, sheets, wall art, carpet, lamps, mirror, and trash can. Resident 2 moved in 6 days prior to inspection from Harrison House and we were not aware [redacted] was storing used briefs with [redacted] clean clothes and that the resident keeps on a brief saturated with urine and layers it with another brief.

The Administrator and Assistant Administrator are responsible for correcting the problem.

The Assistant Administrator advised the direct care staff on 09/08/2023 that Resident 2 needs toilet checks every 2 hours, and that [redacted] must be reminded to change [redacted] briefs throughout the day. Assistant Administrator also advised the direct care staff that Resident 2's sheets and soiled clothes must be washed by 9:00 AM and checked throughout the day to make sure they are not soiled. Assistant Administrator advised the direct care staff that the trash can in Resident 2's room must be emptied when a soiled brief is present. Assistant Administrator/Administrator will check the room at least twice daily to make sure the cleaning routine for Resident 2's room is being followed and check with staff weekly whether they are following the toileting schedule.

Resident 3 had their [redacted] checked in error on the [redacted] of Resident 1 on [redacted]. PCH ordered a [redacted] on [redacted] from Health Direct Pharmacy for Resident 1. Assistant Administrator labeled all glucometers with each resident's name. Administrator reviewed the 5 Rights of medication with all staff and they were informed to match the name on the [redacted] with the resident prior to taking the glucose reading.

Administrator/Assistant Administrator will conduct weekly checks to make sure the [redacted] readings on the [redacted]

Proposed Completion Date: 09/08/2023 [redacted]; 09/11/2023 [redacted]

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] 11/13/2023)

103e - Left Overs

6. 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

The refrigerator in the main kitchen contained a Ziplock bag of cooked noodles and a plastic container of cooked rice. Neither of the items were labeled or dated.

Plan of Correction ***Accept [redacted] - 10/12/2023)***

All staff have been verbally reminded any leftovers or opened food packages must be labeled and dated prior to being placed in the refrigerator and/or freezer. Staff will check the refrigerator before the end of their shift to make sure all leftover and open items placed in the refrigerator/freezer have been labeled. Administrator placed a sign on the refrigerator reminding staff all leftover/open items must be labeled and dated in the refrigerator/freezer.

Licensee's Proposed Overall Completion Date: *10/07/2023*

Implemented [redacted] - 11/13/2023)

103f - Refrigerator/Freezer Temps

7. 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

There was no thermometer to determine the temperature of the medication refrigerator that stores the home's insulin.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

A thermometer was placed in the medication refrigerator. The Administrator/Assistant Administrator will do weekly checks to ensure all refrigerators/freezers have a thermometer and the reading is below 40 degrees. Staff have also been informed to notify Administrator/Assistant Administrator if they don't see a thermometer or the thermometer doesn't read below 40 degrees.

Licensee's Proposed Overall Completion Date: *10/07/2023*

Implemented [redacted] - 11/13/2023)

121a - Unobstructed Egress

8. 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 on the right side rear lower level was obstructed from the outside by a door frame and a plastic cylinder so that the door could not open freely.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

Administrator will make sure on a daily basis no stairways, hallways, passageways, and routes of egress are obstructed and not locked.
The Administrator/Owner removed the door frame and plastic cylinder placed outside of the right side lower rear level exit door on 09/10/2023.

Licensee's Proposed Overall Completion Date: *10/07/2023*

Implemented [redacted] - 11/13/2023)

132c - Fire Drill Records

10. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

8 of the last 12 fire drills completed by the home were documented as being completed in 120 seconds. Staff Member C completed the fire drills and stated that they would document 120 seconds even if the drill was completed in less time.

132c - Fire Drill Records *(continued)*

Plan of Correction ***Accept [redacted] - 10/18/2023)***

The Administrator will keep a written fire drill record including the date, the exact time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating as well as any problems encountered with the fire alarm or smoke detector.

The Administrator will monitor the problem and hold the next drill within 30 days from the and will keep a written fire drill record (log) which will include the date, the exact time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating as well as any problems encountered with the fire alarm or smoke detector.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] 11/13/2023)

132d - Evacuation

11. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have an extended evacuation time designated by a fire safety expert and must evacuate within 2 ½ minutes. On 3/21/2023, the home completed their fire drill in 5 minutes and 5 seconds. On 4/27/2023, the home completed their fire drill in 3 minutes and 50 seconds.

Plan of Correction ***Accept [redacted] 10/18/2023)***

The Assistant Administrator contacted the Fire Chief of the Hazleton Fire Department on 09/08/2023 and requested a letter which stipulates an extended evacuation time based on the structure. The Assistant Administrator will follow-up with the Hazleton Fire Department regarding this request again on 10/17/2023 for their determination.

The Administrator/Assistant Administrator will also continue to have unannounced and scheduled fire drills to reduce evacuation times at least one time monthly and host at least one drill annually. The Administrator/Assistant Administrator will contact the Hazleton Fire Department and schedule an annual fire drill and request suggestions/tips for reduced evacuation times. The Administrator will also make sure there is a wheelchair readily available in any resident's room if they begin to experience mobility issues which was the cause of one of the extended evacuation time on 04/27/2023.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/13/2023)

132e - Fire Drill Sleeping Hours

12. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

132e - Fire Drill Sleeping Hours *(continued)*

Description of Violation

There has been no fire drill completed during sleeping hours with in the last 15 months from 6/2022 through 8/2023.

Plan of Correction ***Accept [redacted] - 10/18/2023)***

On 09/10/2023 the Assistant Administrator talked with the staff and residents about the importance of fire safety and participating in fire drills. Administrator is responsible for the problem, will monitor compliance, and will hold at least 1 unannounced fire drill at least every 6 months and record the drill in the fire drill record. The Administrator will hold an unannounced night time drill before 10/31/2023.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/13/2023)

132f - Alternate Exit Routes

13. Requirements

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

Description of Violation

The home has used the side entrance for their last 7 fire drills and 10 of their last 12 fire drills.

Plan of Correction ***Accept [redacted] - 10/18/2023)***

On 09/10/2023 the Assistant Administrator spoke with the staff and residents about the importance of fire safety and participating in fire drills and the use of alternate exit routes. The Administrator/Assistant Administrator are responsible for and will hold a fire drill at least every 30 days and use different exit routes for each drill including the side and front entrances leading to a designated safe meeting place. The Assistant Administrator/Administrator will record the drill in the fire log.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/13/2023)

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:

Description of Violation

The ground at the outdoor area designated for smoking contained numerous cigarette butts disposed of on the ground.

Plan of Correction ***Accept [redacted] - 10/12/2023)***

The PCH resident contract states, smoking is only in designated areas and new residents who smoke are escorted to the designated smoking areas outside. The PCH received 3 new residents from Harrison House who are smokers and were not accustomed to the PCH's smoking rules. Staff routinely go outside and re-direct smokers to the designated smoking area if they are not in the appropriate place to smoke outside. All cigarette butts were disposed of on the ground by the Administrator on 09/09/2023 and the Administrator also met the smokers about the policy during lunch time.

Licensee's Proposed Overall Completion Date: *10/07/2023*

144c1 - Smoking Area Guidelines *(continued)*

Implemented (- 11/13/2023)

183b - Meds and Syringes Locked

15. 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

The medication cart was found unlocked in an unlocked and unattended room at the time of inspection.

Plan of Correction ***Accept (- 10/18/2023)***

Administrator met with all staff on 09/10/2023 and reminded all staff the med room containing meds & syringes must be locked at all times except when a staff person is trained in Medication Administration is present in the Med room.

On 10/07/2023 the Administrator has made an extra key for additional staff trained in Medication Administration to utilize to have access to locked med room. Administrator/Assistant Administrator are responsible for and will monitor by doing checks throughout the day to make sure the med room is locked when unattended.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented - 11/13/2023)

183f - Discontinued Medications

16. 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

There was an open for Resident 4 of that was not dated when opened. The medication expires 28 days after being opened according to the manufacturer label.

Plan of Correction ***Accept - 10/18/2023)***

The Assistant Administrator discarded Resident 4's on and replaced the opened, unlabeled pen with a new and marked the date it was opened.

On 10/04/2023 The Administrator reviewed Medication Administration guidelines pertaining to discontinued medications. All staff trained in medication administration will mark when and any other medication are opened as indicated by the manufacturer and discard of any expired prescribed medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home.

The Administrator/Assistant Administrator will do weekly checks to make sure discontinued medications are discarded according to medication disposal guidelines.

183f - Discontinued Medications *(continued)*

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/13/2023)

185a - Implement Storage Procedures

17. 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 documentation indicated a [redacted] level of [redacted] on [redacted]. This reading was not found on the resident's glucometer.

Plan of Correction ***Accept [redacted] - 10/18/2023)***

The documentation indicated a [redacted] level of [redacted] on [redacted]. This reading was not found on the resident's [redacted].
The documentation indicated a [redacted] level of [redacted] on [redacted] This reading was not found on the resident's [redacted] because it is not adjusted with the right time, and it was on the wrong [redacted]. A new [redacted] was purchased. Administrator adjusted the time on the new [redacted] to reflect the correct date and time.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented (CP - 11/28/2023)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident 3 has a prescription to receive [redacted] daily [redacted]. On 9/7/2023, Staff member B administered [redacted] in error.

Repeat Violation 6/22/2023.

Plan of Correction ***Accept ([redacted] - 10/18/2023)***

On 09/07/2023 the Assistant Administrator requested another refill of [redacted] from Health Direct Pharmacy and reviewed the prescriber's orders for the next scheduled medication administration. Assistant Administrator also discarded the [redacted] that was discontinued.
On 10/04/2023 the Administrator reviewed the Medication administration guidelines pertaining to following prescribed orders and included a review of these steps:
1. Wash your hands and gather the necessary supplies.
2. Remove the patient's medication from the storage area.
3. Check the label on the bottle or card and pick the medication to be administered.
4. Compare the medication administration record with the label to make sure they correlate.

187d - Follow Prescriber's Orders (continued)

5. Identify the patient and explain what you're going to do.
6. Follow prescribed order to administer the medication.
7. Document the medication on the administration record.
The Administrator is responsible for the problem, and will continue to complete monthly check-ins and tips for medication administration.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/13/2023)

225a - Assessment 15 Days

19. 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

The assessment for Resident 1 was not completed within 15 days of their admission. Their admission date was [redacted] and the assessment was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 10/18/2023)***

The Resident 1 moved into the facility on [redacted], not [redacted] as the report states. A pre-admission screening was completed by the Administrator on his move-in date on [redacted] and was on file in the electronic record not in the physical record.
The Administrator will print all required records from the electronic record and place in each resident's physical file. The Assistant Administrator and Administrator are responsible for and will monitor each residents' records within 15 days of their move in date to make sure the assessment has been completed, printed and placed in their record. Proposed Completion Date: 10/21/2023 to have all required documents printed and placed in resident's files.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted] 11/13/2023)

227a - Support Plan 30 Days

20. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

The support plan for Resident 1 was not completed within 30 days of their admission. Their admission date was [redacted] and the support plan was completed on [redacted]

Plan of Correction ***Accept [redacted] - 10/18/2023)***

Resident 1 moved into the PCH on [redacted] not [redacted] as the report states. Resident 1's support plan was completed on [redacted] by the Administrator.
The Administrator/Assistant Administrator will complete a written support plan developed and implemented within

227a - Support Plan 30 Days (continued)

30 days of the resident's admission to the home. The support plan shall be documented on the Department's support plan form.

The Administrator/Assistant Administrator are responsible for, will monitor, and will make sure the support plan is completed, printed and placed in the resident's file within 30 days of admission.

Licensee's Proposed Overall Completion Date: *10/18/2023*

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

227d - Support Plan Medical/Dental

21. 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 most recent RASP dated [redacted] for Resident 5 was not updated to show that they have been receiving wound care since [redacted].

Plan of Correction ***Accept [redacted] - 10/12/2023)***

The Administrator will check resident's charts weekly to ensure necessary changes related to medical, dental, vision, hearing, mental health and/or behavioral health services requested by their medical, behavioral and dental team are documented in the record within 5 days of the request.

The support plan of Resident 5 was updated to show wound care ordered by [redacted].

Licensee's Proposed Overall Completion Date: *10/07/2023*

Implemented [redacted] 11/13/2023)