pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **PREMIER OAKWOOD TERRACE OPERATING LLC**
LEGAL ENTITY

To operate **OAKWOOD TERRACE**
NAME OF FACILITY OR AGENCY

Located at **400 GLEASON DRIVE, MOOSIC, PA 18507**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **58**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 13**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **April 23,** **2024** until **October 23,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226612**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 23, 2024

[redacted]
Premier Oakwood Terrace Operating, LLC
400 Gleason Drive
Moosic, Pennsylvania 18507

RE: Oakwood Terrace
License: 226612

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 7, 2023, November 8, 2023, November 14, 2023, January 16, 2024, January 19, 2024, February 7, 2024, and February 16, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 226611) dated October 13, 2023, to April 13, 2024, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated October 13, 2023, to April 13, 2024, is NOT reinstated upon expiration of this SECOND PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from April 23, 2024 to October 23, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
16c	III	36	$3	$108	15 calendar days from mailing date of this letter
42b	II	36	$5	$180	5 calendar days from mailing date of this letter
225a	II	36	$5	$180	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary>

cc: [redacted]

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

Facility Information

Name: *OAKWOOD TERRACE* **License #:** *22661* **License Expiration:** *04/13/2024*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: *400 GLEASON DRIVE, MOOSIC, PA, 18507*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/02/1998* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *41* **Waking Staff:** *31*

Inspection Information

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

Reason: *Provisional, Incident, Interim* **Exit Conference Date:** *02/16/2024*

Inspection Dates and Department Representative

02/16/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served:** *36*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *The Pines* **Capacity:** *13* **Residents Served:** *0*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *36*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *5* **Have Physical Disability:** *0*

Inspections / Reviews

02/16/2024 - Full

Lead [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/22/2024*

Inspections / Reviews *(continued)*

04/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

04/12/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *04/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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) reports dated 5/31/23 and 11/27/23 posted conspicuously in the home as required.
Repeated Violation 5-31-23.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during rounding with the inspector we came upon the posting of Oakwood's inspection summary, it was noticed 5/31/23 and 11/27/23 posting wasn't in the sleeve with the other posting. This violation was immediately taken care of in front of Inspector and now is currently up to date of all inspections.
Moving forward it is the Administrator job to comply with DHS reg 2600 3.c and as well do an audit to make sure all current inspections and well as future are posted for the public. This audit will be part of our POC improvement plan as well in QA to comply with all violations to comply with no repeat violations.

Proposed Overall Completion Date: 03/22/2024.

(Directed)
The administrator will ensure that the current license and a copy of all violation reports where full compliance has not been verified are posted in a conspicuous and public place within the home. Copies of the violation reports and plans of correction will also be available for review upon request of the residents or their designated persons. The home will document and complete weekly audits for the first 3 months.

Directed Completion Date: *04/27/2024*

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The LIS dated 8/18/23 was posted with the privacy coding sheet attached to it, revealing confidential resident information.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during rounding with the inspector we came upon the posting of Oakwood's inspection summary, it was noticed that LIS on 8/18/2023 contained a resident's name. This violation was immediately corrected in front of the inspector as well went through all inspections to comply with reg 2600. 17. All management team was reminded of this regulation and the Administrator will be monitoring.
Moving forward an audit was done as well now put into place to comply with this regulation. It will be part of our POC and QA meeting to ensure we are compliant.

17 - Record Confidentiality (continued)

Proposed Overall Completion Date: 03/22/2024
(Directed)
The home will document and complete weekly audits for the first 3 months.

Directed Completion Date: *04/27/2024*

26b - Quality Management Plan Content

3. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.

Description of Violation

The home did not have documentation that a Quality management meeting was held to review the topics required under this regulation in 2023.
Repeated Violation 5-31-23.

Plan of Correction ***Directed [redacted] 03/28/2024)***

On 2/16/2024 during an exit interview with the inspectors it was noted that we did not comply with reg 2600 26b to ensure the home had a Quality Management Meeting. After this finding we immediately implemented a Quality Management Meeting.
Under the supervision of the Administrator a Quality Management Meeting will be added to our stand-up morning routine.
This has been and will be taking place weekly. An audit took was created to comply with reg 2600 26b.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The home's quality management plan will be amended to include, at a minimum:
(1) The date the administrator and executive staff will review the effectiveness of the reportable incident and condition reporting procedures developed as required by 2600.16b, and a plan to correct any errors or inefficiencies identified during a review or all incidents reported within the past year.
(2) The date the administrator and executive staff will review all of the complaints received from residents within the past year, a plan to reduce future complaints, and a review of how the home addressed each complaint in accordance with the requirements of these regulations.
(3) A plan to review all training provided to direct care staff within the past year, addressing which trainings were effective, which were not effective, and what additional training courses would be helpful.
(4) A review of all of the violation reports received within the past year, and a complete self-inspection using the Department's licensing measurement instrument.
(5) The development and maintenance of a resident council.
The home will document audits for the next 3 months.

Directed Completion Date: *04/27/2024*

42s - Privacy

4. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Resident #1 was walking in a hallway when the resident fell backwards. An incident report dated 2/12/24 indicates that recorded camera footage was reviewed of the resident walking in the hallway and falling. Homes are not permitted to record in common areas of the home.
Repeated Violation 5-31-23.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/24 during the inspectors exit interview it was determined that Oakwood Terrace had a camera that was recording of a hallway. On 2/16/2024 the Director of Maintenance immediately disconnected the camera and all other cameras that were internal in all resident common areas.
Moving forward Oakwood Terrace will follow reg 2600 42.s for privacy of all residents while in the home.
This violation and not allowing repeat violation will be the sole responsibility of the Maintenance Director as well the Administrator to stay compliant with this violation. As well implement this into our POC and AQ reviews.

Proposed Overall Completion Date: 03/22/2024
(Directed)
The home will ensure that the right to privacy of self and possessions is protected.

Directed Completion Date: *04/27/2024*

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

The home currently has 35 residents. On the following dates and times, there were no staff present in the home with current First aid/CPR training:
2/9/24 11pm-7am
2/10/24 11pm-7am
2/11/24 7am-3pm and 11pm-7am

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview it was noted that during wellness 11pm-7am shift did not have a certified cpr employee. After the exit interview the Administrator, Wellness Director and Business Office Manager did an audit of all current staff members trainings that pertain to this reg 2600 63a. After this audit was completed, we established that a CPR training is and was needed.
An active cpr certified employee now has been switched to that shift until we can all staff members in compliance with the regulation to not repeat this violation.
This requirement will be the responsibility of the Business Office Manager as to make sure all trainings are accurate and current as well as the Wellness director.
As well the Administrator will be Soley responsible of setting up CPR/ First Aide training regularly to stay in

63a - First Aid/CPR Training (continued)

compliance for all wellness shifts staff members as well in the building.

Proposed Overall Completion Date: 03/22/2024
(Directed)
The administrator will ensure that sufficient numbers of staff with the required training and certification are present in the home at all times. Documentation of staffing, training, and certification will be available to agents of the Department at any time.

Directed Completion Date: *04/27/2024*

65b - Rights/Abuse 40 Hours

6. 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:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff persons A did not have training in the topics required under this regulation within 40 hours of their first day of work.
Repeated Violation 5-31-23.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspectors noted staff member A did not the initial 40 hour of training that is required for reg 2600 65.b. After this repeated violation the Business Office Manager and Administrator came up with a training plan to ensure all staff members will and have met this regulation. After completing this audit, we established multiple employees are not in compliance with this requirement. We implemented the 40-hour trainings as well as others current employees that have never had this training. All staff will be required to have this training completed by 4/1/24.

Proposed Overall Completion Date: 03/22/2024
(Directed)
The identified staff persons will have all of the training required by this regulation. Documentation of training will be kept in accordance with 2600.65i.

The administrator will develop and implement a system to ensure that all newly-hired staff persons receive the training required by this regulation within 40 scheduled working hours.

Directed Completion Date: *04/27/2024*

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

65e - 12 Hours Annual Training *(continued)*

Description of Violation

Staff person C did not have 12 hours of documented training hours for the 2023 training year.
Repeated Violation 5-31-23.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspectors noted staff member c did have annual 12 hour of training that is required for reg 2600 65.e. After this repeated violation the Business Office Manager and Administrator came up with a training plan to ensure all staff members will and have met this regulation. After completing this audit, we established multiple employees are not in compliance with this requirement. We implemented the 12-hour trainings as well as others current employees that have never had this training. All staff will be required to have this training completed by 4/1/24.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The identified staff persons will have (12 + missing hours) of training. The training topics will include those required by this Chapter at a minimum. Documentation of training will be kept in accordance with 2600.65i.

Directed Completion Date: *04/27/2024*

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff person C did not have training in the topics required under this regulation for the 2023 training year.
Repeated Violation 5-31-23.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspectors noted staff member C did have annual 12 hour of training that is required for reg 2600 65.F . We also, established that these topics were not included. Relias platform we established multiple differed modules to meet this requirements for the courses needed. After this repeated violation the Business Office Manager and Administrator came up with a training plan to ensure all staff members will and have met this regulation. After completing this audit, we established multiple employees are not in compliance with this requirement. We implemented the trainings that is required about this reg as well as all others for current employees that have never had this training will be required to meet this regulation. All staff will be required to have this training completed by 4/1/24.

Proposed Overall Completion Date: 03/22/2024

65f - Training Topics (continued)

(Directed)

The administrator will develop a staff training plan that includes the following information:

(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and regularly-scheduled volunteer

(2) The required training courses for each person identified in (1).

(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.

The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g.

The home will implement the developed plan. Compliance with the plan will be kept in accordance with 2600.65i and 2600.66c.

Directed Completion Date: *04/27/2024*

65g - Annual Training Content

9. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons C and D did not have training in the topics required under this regulation for the 2023 training year. Repeated Violation 5-31-23.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspectors noted staff member C did have annual 12 hour of training that is required for reg 2600 65.g . We also, established that these topics were not included. Relias platform we established multiple differed modules to meet these requirements for the courses needed. After this repeated violation the Business Office Manager and Administrator came up with a training plan to ensure all staff members will and have met this regulation. After completing this audit, we established multiple employees are not in compliance with this requirement. We implemented the trainings that is required about this reg as well as all others for current employees that have never had this training will be required to meet this regulation. All staff will be required to have this training completed by 4/1/24.

Proposed Overall Completion Date: 03/22/2024

(Directed)

The administrator will develop a staff training plan that includes the following information:

(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and

65g - Annual Training Content (continued)

regularly-scheduled volunteer

(2) The required training courses for each person identified in (1).

(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.

The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g.

(Directed)

The home will implement the developed plan. Compliance with the plan will be kept in accordance with 2600.65i and 2600.66c.

Directed Completion Date: *04/27/2024*

89b - Hot Water Temperature

10. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The temperature of the hot water in the bathroom of resident room Willow #1 measured 124.1 degrees Fahrenheit at time of inspection.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during the walk around with one of the inspectors [redacted] recorded room Williow 1 temperature was above the regulation of 2600 89b. The Maintenace director has not started a water temperature log. This log will be put into our QA meetings to make sure we are in compliance of this regulation. The Maintenace Director and Administrator will monitor this until we clear this violation as well as monitor it for no further repeated violations.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The hot water temperature will be adjusted such that it does not exceed 120°F in any area accessible to residents.

The administrator will check the water temperature in areas accessible to the residents to ensure that it is 120°F or less. Any area that exceeds this temperature will be adjusted immediately.

Directed Completion Date: *04/27/2024*

96a - First Aid Kit

11. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The home's first aid kit was missing tweezers, a thermometer, and a CPR breathing shield.

Plan of Correction ***Directed [redacted] 03/28/2024)***

On 2/16/2024 during rounding's of the building the Inspector identify a first aid kit was missing some items that are required under reg 2600 96a. After hearing this finding, we immediately purchased all items that were missing into the current first aid kit. As well as now we have two backups always on hand for any reason of items to be missed.

96a - First Aid Kit (continued)

The Maintenace Director, Wellness Director and Administrator will be Soley responsible for this to always be accurate of the items that are needed.

Proposed Overall Completion Date: 03/22/2024
(Directed)
The home will be equipped with a first aid kit that contains all of the required items. The administrator will check first aid kit supplies at least twice per month and after each use to ensure that all of the items inside are present and usable. The home will document audits.

Directed Completion Date: *04/27/2024*

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 drill on 6/9/23 at 12:36am. The home did not conduct another sleeping hour drill six months later in December 2023 as required.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during the exit interview the inspector advised that we did not have a overnight fire drill since June of 2023. This violation was immediately discussed with the Maintenance Director to make sure we get into compliance of this regulation.
March of 2024, we conducted a overnight sleeping hour fire drill. As we created a fire drill schedule to make sure we are in compliance. The maintenance director and Administrator will be the sole responsibility of making sure there is not a repeat violation.

Proposed Overall Completion Date: 03/22/2024
(Directed)
Next monthly fire drill and every six months thereafter the home will hold a fire drill between 11PM and 6 AM.

Directed Completion Date: *04/27/2024*

144c1 - Smoking Area Guidelines

13. 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

There were approximately a dozen cigarette butts observed on the ground mixed with dried leaves in the home's outdoor designated smoking area.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during rounding with the inspectors they noticed cigarette butts in the designated smoking area.

144c1 - Smoking Area Guidelines (continued)

After the exit interview that area was cleaned by housekeeping staff. There is also a posting of this violation and regulation 2600 144c in the designated smoking area. Moving forward this will be part of the housekeeping staff task list. As well as this will be part of the Maintenace Director responsibilities to ensure this area is clean and not a hazard. The Administrator will follow up with this violation on a weekly basis with the designated staff for compliance.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The home will develop and implement the required procedures. The procedures will address all of the elements required by this regulation. The administrator will document weekly audits.

Directed Completion Date: *04/27/2024*

182b - Prescription Medication

14. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

The following staff persons are currently administering medications without being certified to do so:
Staff Person C– current Annual practicum dated 9/5/2023 documents only 1 MAR review and 1 medication administration observation.
Staff Person E – last certified 11/16/22 – current Annual Practicum dated 11/16/23 documents only 1 Medication Administration Record (MAR) review and 1 medication administration observation.
Staff Person F– most current Annual practicum is dated 1/17/23
Staff Person G– current annual practicum dated 8/2023 documents only 1 medication administration observation.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during the exit interview it was determined by the inspectors that medtechs were only observed doing a single observation for their yearly review. The Wellness Director currently established a list of all medtechs that are not in compliance of this regulation. We immediately identified that our Wellness Director will be our med tech train the trainer for Oakwood Terrace. [redacted] has completed [redacted] course now waiting on a face-to-face final exam. Once completed as that date is set for April 4, 2024, the Wellness Director will be the sole responsibility getting all current staff members in compliance as well as for all future staff members.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The administrator will register a qualified staff person to attend the Department's approved Train the Trainer course provided the course can be completed within 15days and allowing 15 days to train the home's staff.

Directed Completion Date: *04/27/2024*

182c - Medication Administration

15. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

Resident #2 has an order for Tylenol 500 mg, four times daily. The resident did not receive the 1pm dose of this medication. At approximately 3:00pm, the medication was in a cup in the top drawer of the medication cart and identified by staff person E as the resident's 1pm dose. Resident #2's MAR was initialed that this medication was administered at 1pm.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during the exit interview inspector noted the following violation of regulation 2600 182.c After hearing of this violation, Wellness Director and Administrator had a discussion and counseling session with this staff person. Staff E was put on a corrective action plan and a written violation of this regulation. During wellness meeting on 3/21/2024 all staff members handling meds were reminded of this requirement. Moving forward this is the reasonability of the Wellness Director to do random audits to make sure we are not allowing this trend or repeat violation.

Proposed Overall Completion Date: 03/22/2024
(Directed)
All medication techs will be trained on regulation 182c and documented. All random audits will be documented by the home's administrator. The home will administer medications in a manner consistent with these regulations.

Directed Completion Date: *04/27/2024*

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 28 units of Basaglar insulin every morning. The pharmacy label on the insulin pen states the order is for 15 units of Basaglar insulin at bedtime.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspector noted this violation on regulation 2600 184a. The Wellness Director immediately contacted the doctor and pharmacist to confirm order. This order was corrected on the insulin pen. Moving forward there will be weekly audits to match the MAR/ Orders to the actual label in the Medart as well per each resident. After this violation we contacted the pharmacy to enhance a med cart audit. Moving forward the Wellness Director will rotate shift supervisors to conduct a weekly audit to comply with this regulation.

Proposed Overall Completion Date: 03/22/2024

The home will document all weekly medication cart audits.

Directed Completion Date: *04/27/2024*

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

Resident #2 has an order for Dextromethorphan ER, 10ml every 12 hours as needed for cough. The home did not have this medication available to administer if needed.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspector noted this violation on regulation 2600 185.a. The Wellness Director immediately contacted the pharmacy for stat run of this medication. After doing this the medication was available within the next delivery run of the pharmacy. We also established a backup pharmacy to assist with our current in-house pharmacy to ensure we're in compliance of having all residents' meds on hand. We also established a new way of tracking miss meds or med errors to the medical prescriber. The Wellness Director is the sole reasonability individual that we stay in compliance. We also have added this to our QA/ Risk management meetings to ensure this does become a repeat violation.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The home will develop the required procedures. The procedures will include, at a minimum:
1. Use of a medication delivery log that documents the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors, including who is responsible for completing the investigation, how the investigation will be completed, and how the findings will be reported to the Department.
3. Policy and procedures for locking medications, and which staff persons will have access to the medications.
4. Use of a Medication Administration Record as required by 187a-d.

All staff who administer medications will be trained on the procedures. Documentation of training will be kept.

Directed Completion Date: *04/27/2024*

187a - Medication Record

18. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #2 has an order for Guaifenesin 5ml every 4 hours as needed. The home administered this medication on the following dates: 2/2/24 through 2/5/24, 2/7/24 through 2/9/24 and 2/12/24 through 2/14/24. The home's staff initialed the wrong medication on the MAR for these medications. Staff initialed the medication Dextromethorphan ER instead, which was not in the medication cart.

Resident #3 has an order Lispro insulin to be administered with meals on a sliding scale basis. The home is not documenting the number of sliding scale insulin units administered at meal times.

187a - Medication Record *(continued)*

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspector noted this violation on regulation 2600 187a. The Wellness Director immediately contacted the pharmacy and medical provider to establish the correct MAR for resident 2. This was established as an error of pharmacy implementing meds for the home. The pharmacy profiles the meds for the home for pending review of the Wellness Director.
Moving forward the Wellness Director will be doing weekly audits until compliance is met to maintain this regulation as well as no repeat violations. All med errors are also implemented into our Risk / QA meetings.

Proposed Overall Completion Date: 03/22/2024
(Directed)
The home will amend residents' MARs to ensure that all of the required information is captured. The home will document weekly audits.

Directed Completion Date: *04/27/2024*

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #2 has an order for Tylenol 500mg, 1 tablet four times daily. On 2/16/24 the resident did not receive their 1pm dose of the medication.
Resident #2 also has an order for Eliquis 5mg, 1 tablet twice daily. On 2/16/24 the resident did not receive the 9am dose due to the medication not being on hand to administer.
Repeated Violation 5-31-23, 8-18-23.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspector noted this violation on regulation 2600 187 d. The Wellness Director established the breakdown with staff members immediately. We have created a form to help ensure all parties are aware of missed meds. All staff members that handle resident meds were advised of this violation as well regulation and signed off of the requirement. Moving forward the Wellness Director as well as Administrator will be monitoring daily medication review via Eldermark MARs tracking for any violations as well as any corrective actions with staff members. This MAR review is now implemented into a weekly risk management to ensure no repeat violation occur.

Proposed Overall Completion Date: 03/22/2024
(Directed)
The home will document all MARs audits going forward.

Directed Completion Date: *04/27/2024*

227d - Support Plan Medical/Dental

20. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

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

Resident #9's support plan dated 10/11/23 was not updated to reflect that the resident had an incident of aggression towards another resident on 1/2/24 and did not include a plan to address and prevent future behaviors.

Plan of Correction ***Directed [redacted] 03/28/2024)***

On 2/16/2024 during exit interview inspector noted this violation on regulation 2600 227.d After hearing this violation a weekly RASP intervention has been established to ensure all changes outside of resident's base line is addressed into their RASP. This meeting is taken place while each standup meeting to ensure accuracy and corrective action is taken place immediately. This is the sole responsibility of the Wellness Director as well Administrator to ensure this is not a repeat violation. Attachment states what is discussed as well as stating if concern was addressed as updated to each individual support plan.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The home will document weekly RASP audits.

Directed Completion Date: *04/27/2024*

231b - Medical Evaluation

21. 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

The following residents have Documentation of Medical Evaluation (DME) forms that indicate the residents require secure dementia care, but are not currently residing in a secure dementia area of the home:
Resident #4's DME is dated 2/2/24 and indicates Secured Dementia Care
Resident #5's DME is dated 2/2/24 and indicates Secured Dementia Care
Resident #6's DME is dated 2/2/24 and indicates Secured Dementia Care
Resident #7's DME is dated 2/2/24 and indicates Secured Dementia Care
Resident #8's DME is dated 2/2/24 and indicates Secured Dementia Care

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspector noted this violation on regulation 2600 231B. This violation was towards the secured unit for residents DMEs. The Administrator was in contact with DHS acting regional pertaining the time of opening up our secured unit on Oakwood Terrace. The current residents 4-8 stated an old DME that was no longer valid as the unit was not secured on the inspection date of 2/16/24. Oakwood Terrace opened up the Secured Unit on 2/23/24. All current residents in the secure unit have an updated DME that is dated of the opening date as well all residents were in the secured unit with in the 72-hour time frame. All DMEs dated with a status change are within date range. All communications leading to the secure unit has already been taken place with

231b - Medical Evaluation (continued)

DHS representee's prior to inspection on 2/16/2024. Any further residents needing a secure unit will be the responsibility of the Wellness Director and Administrator to make sure all DMEs are dated and filled out correctly and meets the requirements for a secured unit.

Proposed Overall Completion Date: 03/22/2024
(Directed)
The identified resident(s) will have a medical evaluation that addresses all of the areas required by 2600.141a. Documentation of the evaluation will be made on form MA-51. The documentation will 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.

The home will ensure that residents receive medical evaluations within the time frames specified by this Chapter and with the required information.

Directed Completion Date: *04/27/2024*

236 - Staff Training

22. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Staff person C provides direct care to residents and was hired on [redacted]. Staff person C did not receive 6 hours of dementia related training during the 2023 training year.

Plan of Correction ***Directed [redacted] - 03/28/2024)***

On 2/16/2024 during exit interview inspector noted this violation on regulation 2600 236. On 2/23/2024 the Business Office Manager, Wellness Director and Administrator established that wellness staff needed this additional training. this additional training was given to all direct care staff members. This is now part of our QA follow up to ensure no repeat violations occur with this regulation. All trainings of
Alzheimer's Disease and Related Disorders: Behaviors - 1 Hour
Alzheimer's Disease and Related Disorders: Communication Needs - 1 Hour
Alzheimer's Disease and Related Disorders: Ethical and Family Issues - 1 Hour
Alzheimer's Disease and Related Disorders: Psychosocial Needs - 1 Hour
Alzheimer's Disease and Related Disorders: The Environment - 1 Hour
Communication and People with Dementia - 1 Hour.
The Administrator and Business Office Manager will be the sole reasonability of making sure all direct care staff receive these additional training as well as their annual training.

Proposed Overall Completion Date: 03/22/2024
(Directed)

The home will train all staff in 6 hours of required dementia training. The home will document the 6 hours of training for each staff member.

236 - Staff Training *(continued)*

Directed Completion Date: *04/27/2024*

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

Facility Information

Name: *OAKWOOD TERRACE* **License #:** *22661* **License Expiration:** *04/13/2024*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: *400 GLEASON DRIVE, MOOSIC, PA, 18507*

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *35* **Total Daily Staff:** *105* **Waking Staff:** *79*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *02/07/2024*

Inspection Dates and Department Representative

02/07/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served:** *35*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *entire home* **Capacity:** *58* **Residents Served:** *35*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *35*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *35* **Have Physical Disability:** *0*

Inspections / Reviews

02/07/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/02/2024*

Inspections / Reviews *(continued)*

03/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/08/2024*

03/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/17/2024*

04/01/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

16c - Written Incident Report

1. 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]-24, Resident # 1, while gripping [redacted] walker at arm's length from [redacted] body, moved forward, fell forward, and fell to the floor, face first. [redacted] injured [redacted]r face and broke both of [redacted] arms.

[redacted]e began to call out in pain and for assistance. Staff responded immediately, grasped the situation and called 911. The resident was transported to a local hospital for treatment and surgery.

The home failed to report this serious injury and subsequent treatment of the resident within the required 24 hours to the Northeastern Regional Office.

Repeat violation: 5/31/23, 3/30/23

Plan of Correction ***Directed [redacted] - 03/07/2024)***

Oakwood Terrace developed an audit sheet for making sure all reportable are done in a timely manner. Also, now a sheet is added to shift report to state if any residents were sent out to the hospital as well as any incident reports. This will be the responsibility of the Wellness Director as well as the Administrator. This will be also included in risk assessment meetings.

Proposed Overall Completion Date: 03/06/2024

Directed:
The Administrator will immediately and ongoing train all staff in reportable incidents and conditions, as well as the homes internal policy on who is responsible for reporting the incidents to the Department as required including weekends and holidays. The home will keep documentation of the training for review upon the Departments request. All future incidents will be reported as required.

Directed Completion Date: *03/17/2024*

Not Implemented [redacted] - 04/01/2024)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

Upon arrival at the home, and while seeking staff assistance, this worker entered the resident dining room. Immediately inside of the dining room doors were two (2) of the home's medication carts. On the Left side cart there

17 - Record Confidentiality (continued)

was an open and operable Laptop computer with an up and running Medication Administration Record of a current resident showing confidential and protected health information.

Plan of Correction ***Directed[redacted] - 03/07/2024)***

Oakwood terrace - had a privacy practice / hipaa training. As well as added additional privacy training to each employees annual training. This will be the responsibility of the Wellness Director and Administrator as well as BOM to create additional training for all new hires. We also now included this part of our wellness staff meetings in person training.

Proposed Overall Completion Date: 03/06/2024

Directed:
Immediately and ongoing the identified confidential information will be stored in a locked area. All resident records will be confidential and stored in a manner that protects confidentiality that is consistent with this chapter. The Administrator will complete weekly audits to ensure record confidentiality. The home will keep documentation of the audits for review by the Department upon request.

Directed Completion Date: *03/17/2024*

Not Implemented[redacted] - 04/01/2024)

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

Facility Information

Name: *OAKWOOD TERRACE* **License #:** *22661* **License Expiration:** *04/13/2024*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: *400 GLEASON DRIVE, MOOSIC, PA, 18507*

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *76* **Waking Staff:** *57*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *01/19/2024*

Inspection Dates and Department Representative

01/16/2024 - On-Site: [redacted]

01/19/2024 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served:** *38*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Pine* **Capacity:** *13* **Residents Served:** *6*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *38*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *38* **Have Physical Disability:** *0*

Inspections / Reviews

01/16/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/19/2024*

Inspections / Reviews *(continued)*

02/21/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/28/2024*

03/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/27/2024*

04/01/2024 - Document Submission

Submitted [redacted] **Date Submitted**: *03/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16c - Written Incident Report

1. 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 11/17/23, at approximately 6:45am, Resident #1 was witnessed by staff punching Resident #2 in the head in the residents' shared bedroom. Neither resident was injured as a result of the altercation. The home did not report this incident to the Department. The home provided verification that the incident report submission was attempted via fax on 11/17/23 at 3:36pm, but that the fax failed.

repeat violation - 11/7/23; 5/31/23; 3/30/23; 1/18/23

Plan of Correction ***Directed [redacted] - 03/07/2024)***

Oakwood Terrace now created an audit tool to make sure all incidents are being reported. As well as a follow up. Wellness Director and Administrator are responsible to make sure all reportable are sent and received to DHS. Please see attached audit tool.

This tool was created to make sure we do not have the same violations. Our goal is to eliminate violations so we can presume a normal and smooth community for residents as well as a good communication source with DHS.

Proposed Overall Completion Date: 02/26/2024

Directed plan of correction:
The Administrator will immediately and ongoing train all staff in reportable incidents and conditions, as well as the homes internal policy on who is responsible for reporting the incidents to the Department as required including weekends and holidays. The home will keep documentation of the training for review upon the Departments request. All future incidents will be reported as required.

Directed Completion Date: *03/17/2024*

Not Implemented [redacted] - 04/01/2024)

42b - Abuse

2. 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]/17/23 at approximately 6:45am, Staff Person A witnessed Resident #1 standing over Resident #2 while [redacted]e was laying in bed, and Resident #1 was punching Resident #2 in the head. Resident #1 was heard saying "I will kill [redacted]" multiple times after the residents were separated.

Both residents were sent to the hospital for evaluation after the incident. Neither resident sustained injuries as a result of the incident.

42b - Abuse (continued)

repeat violation - 11/7/23, 5/31/23, 1/18/23

Plan of Correction ***Directed [redacted] - 03/07/2024)***

It is Oakwood Terrace primary goal for safety of all residents and staff at the community. As a result of these incidents, we try to investigate as well as get the residents doctor involved to see if there is a new onset or any updated care needs to be met. If they can't be met, we discuss alternate route or possible a 30-day notice of the community. Both residents were discharged from the community.

Ultimately the responsibility of all reports and safety of residents is the Administrator and the Wellness Director which we're working hard for safety.

Proposed Overall Completion Date: 02/26/2024

Directed:
All staff, including the administrator, will receive training in resident rights from an outside source and at the expense of the home. The home will keep documentation of the training for review upon the Departments request. Residents will not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Directed Completion Date: *03/27/2024*

Not Implemented [redacted] - 04/01/2024)

225a - Assessment 15 Days

3. 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's assessment and support plan (RASP) dated 4/5/23 identifies personal care needs regarding bladder management, bowel management, personal hygiene, managing health care, securing health care, doing laundry, securing and using transportation, managing finances, making and keeping appointments, engaging in social and leisure activities, obtaining clean, seasonal clothing, orientation to time, place and person, irritability, aggression, short-term memory. The RASP does not include documentation regarding the description of the services need and/or the home's plan to meet the resident's service need.

repeat violation - 11/7/23, 8/18/23, 5/31/23

Plan of Correction ***Directed [redacted] - 03/07/2024)***

We have implemented audit tool to make sure we're in compliance with all Rasp rules with DHS and its time frame as well meeting the residents care needs.

225a - Assessment 15 Days (continued)

Wellness Director & Administrator will be doing risk assessments including in our daily stand-up meetings to make sure compliance is met for any changes in residents needs or rasp.

Proposed Overall Completion Date: 02/26/2024

Directed:
The home will audit all resident records to ensure all assessments are accurate and complete. The home will create a checklist for new admissions to ensure the required paperwork is completed timely. The home will keep documentation of the audit and checklist for the Department to review upon request.

Directed Completion Date: *03/27/2024*

Not Implemented [redacted] - 04/01/2024)

227d - Support Plan Medical/Dental

4. 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

Per staff interviews, Resident #2 would refuse care and become combative with staff at times when they would attempt to complete the resident's care. Resident #2 also frequently refused meals and wound care from outside home health services. Resident #2 was also the victim of abuse by Resident #1 on 11/17/22, during which Resident #2 was punched in the head by Resident #1. Resident #2's RASP dated 4/5/23 does not include documentation regarding the resident's identified needs or the incident of abuse, as well as the interventions the home has put in place to care for the resident based on this information. Resident #2 also does not document when Resident #2 began receiving home health services for wound care, and what home health staff are responsible for and the facility's staff are responsible for related to the resident's wound care.

repeat violation - 11/7/23; 10/13/23

Plan of Correction ***Directed [redacted] - 03/07/2024)***

See attached. As well as we put a system in place to make sure a 24 hour log is being reported, shower logs being reported to wellness director. Rasp will be updated with any new onsets or requested by resident's medical doctor.

The Administrator and Wellness Director will be holding Rasp, DME meetings to make sure compliance is met for the month.

Proposed Overall Completion Date: 02/26/2024

Directed:
The home will audit all resident records to ensure all support plans are accurate and complete. The home

227d - Support Plan Medical/Dental (continued)

will hold weekly meetings to ensure the residents constantly changing care needs are being addressed and the support plans are being updated accordingly. The home will create a tracking sheet to track these updates during the meetings. The home will keep documentation of the audits, weekly meetings and tracking sheet for updates to the support plan for the Department to review upon request.

Directed Completion Date: *03/27/2024*

Not Implemented [redacted] - 04/01/2024)

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

Facility Information

Name: *OAKWOOD TERRACE* **License #:** *22661* **License Expiration:** *04/13/2024*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: *400 GLEASON DRIVE, MOOSIC, PA, 18507*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/02/1998* **Issued By:** *PA L&I*

Staffing Hours

Resident Support Staff: *1* **Total Daily Staff:** *62* **Waking Staff:** *47*

Inspection Information

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

Reason: *Complaint, Incident, Fine* **Exit Conference Date:** *11/14/2023*

Inspection Dates and Department Representative

11/07/2023 - On [redacted]
11/08/2023 - Off
11/14/2023 - On

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served:** *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *37*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *24*
Have Physical Disability: *0*

Inspections / Reviews

11/07/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/27/2023*

12/12/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/20/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/22/2023*

04/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *12/20/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16c - Written Incident Report

1. 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

Resident #8 is prescribed hydrocodone-acetaminophen 5-325mg 1tab-2x daily. The medication was not on available to administer from 11/4/23 to 11/8/23. The home did not report the medication error to the Department.
Repeat violation: 5-31-23.

Plan of Correction ***Directed [redacted] 12/11/2023)***

The wellness director now how implementing a daily audit check list for any miss meds within a 24-hour period. If any miss meds were missed this would be reported with the state.

Proposed Overall Completion Date: 12/07/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
The administrator will review and audit the incidents required to be reported by 2600.16a with all staff. All future incidents will be reported as required. The administrator will provide training on written incident reports to all staff who are required to report incidents.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 04/11/2024)

42b - Abuse

2. 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 10/3/23, Resident #7 pinned a resident in their chair with Resident #7's walker and Resident #7 was punching the other resident. On 10/23/23, Resident #7 punched another resident in the chest. Then on 10/24/23, Resident #7 was in the community room punching another resident. No injuries noted from any of the altercations. Resident #7 has physically punched three different residents for no apparent reason. Resident #7 has a Dx of dementia and does not recall the events.
Repeat violation: 5-31-23.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Resident #7 has had updated rasp due to [redacted] behaviors as well as changed medications per [redacted] doctor. Also, Oakwood Terrace the Administrator has provided the POA a 30 day notice to vacate the community due to increase behaviors. Noticed was advised on 11/17/2023.

Proposed Overall Completion Date: 12/07/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
All staff, including the administrator, will receive training in resident rights from an outside source.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 04/11/2024)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

Outside of room Pine [redacted] near a small kitchenette area, there was a sticky substance on the floor.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

this was an isolated incident. This was fixed right away before the departure of DHS.

Proposed Overall Completion Date: 12/07/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
The administrator will check all surfaces in the home to ensure that they are clean, in good repair, and free of hazards. And surfaces found to be in need of cleaning or repair will be cleaned or repaired immediately. The administrator will be responsible for all staff checking all surfaces of sanitary conditions on each shift.

Directed Completion Date: *12/22/2023*

Implemented [redacted] - 03/28/2024)

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Residents in rooms Pine 4 and Pine 8 did not have an operable lamp or other source of lighting that could be turned on at bedside.

Plan of Correction ***Directed ([redacted] - 12/11/2023)***

We have created a hall coaching audit tool. Where we as managers will be responsible sections of the building to make sure there is lamp in reach within the bedside of the resident.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
An operable bedside lamp will be added to the identified bedroom #4 and #8. The administrator will create an audit tool to ensure all residents have a bedside lamp. The administrator will check all bedside lamps at least once per week to ensure that they are operable.

Directed Completion Date: *12/22/2023*

Implemented [redacted] - 03/28/2024)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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.

Description of Violation

• The annual DME for resident #1 dated 3/29/23 is missing the following information: height, weight, pulse rate, blood pressure, temperature, and immunization history.

• The annual DME for resident #14 dated 4/24/23 is missing the following information: height, weight, pulse rate, blood pressure, temperature, immunization history, able to self-administer medications and Medical Professional's License #.

• The annual DME for resident #15 dated 8/18/23 is missing the following information: height, weight, pulse rate, blood pressure, temperature, immunization history, able to self-administer medications and Medical Professional's License #.

Repeat violation: 5-31-23, 8-18-23.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Audit tool was put in place and now we follow up for updating DMEs and making sure all sections are filled out in full.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
Residents #1, #14, and #15 shall have their DME updated and corrected. The administrator will ensure that all newly admitted residents have a medical evaluation within the time frames required by this regulation. The administrator will ensure that physicians perform all of the required actions during medical evaluations. The actions will be documented on the DME form. Attachments will be added to the DME form as needed to ensure that all actions are documented. The administrator will audit all residents DMEs to ensure that all DMEs are correct and the DME form is complete in its entirety.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 03/28/2024)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

An annual DME was not completed for the following residents:

• Resident # 11 (DOA [redacted]/22); previous DME completed on 10/3/22.

• Resident # 12 (DOA [redacted]/22); previous DME completed on 6/29/22.

141b1 - Annual Medical Evaluation (continued)

• *Resident # 13 (DOA [redacted]/21); previous DME completed on 6/2/22.*
Repeat violation: 5-31-23.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Audit tool was put in place and now we follow up for updating DMEs and making sure all sections are filled out in full. As well a calendar in place of all residents DME's that are due.

Proposed Overall Completion Date: 12/08/2023.
Residents #11, #12, and #13 annual DMEs be completed within 10 days. The administrator will audit all resident records to ensure that each resident has had a medical evaluation within the past year. Any resident whose medical evaluation is overdue will have a new evaluation as soon as possible and annually thereafter. The administrator will be responsible for completing annual medical evaluations timely.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 03/28/2024)

185a - Implement Storage Procedures

7. 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 glucometer for Resident #10 indicates a blood glucose reading of 99 on 11/5/23 at 8:27pm; it is not documented on the MAR.
The glucometer for Resident #10 indicates a blood glucose reading of 125 on 11/4/23 at 7:57am; it is not documented on the MAR.
Repeat violation: 5/31/23, 8/18/23.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Audit tool was put in place as well as training to all MED TECHS that they must follow the steps of completing the medication dashboard. They will be responsible for recording an accurate reading.

Proposed Overall Completion Date: 12/08/2023
Within 10 days of receipt of this directed plan of correction and ongoing:
The home will ensure all resident #10's blood glucose readings are documented on the resident's MAR. The administrator will complete weekly audits of residents using blood glucose monitoring for accurate documentation of resident's blood glucose numbers. The use of a Medication Administration Record as required by 187a-d. Documentation of training will be kept.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 03/28/2024)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident #8 is prescribed hydrocodone-acetaminophen 5-325mg 1tab-2x daily. The medication was not on available.
Resident #9 is prescribed oxycodone-acetaminophen 5-325mg 1tab-2x every 12 hours as needed. The medication was not on available.
Repeat violation: 5-31-23, 8-18-23

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Audit tool is now in place for our medication dashboard electronic mar to make sure no meds are being missed they're as wellbeing prescribed.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
The home will make sure resident #8 has their medication on hand as prescribed. The home's administrator will complete a medication cart audit within 10 days of receipt. All medication staff will be trained in this regulation. The administrator will conduct monthly medication cart audits to ensure that all residents medications.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 03/28/2024)

188b - Medication Error Reporting

9. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #8 is prescribed hydrocodone-acetaminophen 5-325mg 1tab-2x daily. The medication was not available to administer from 11/4/23 to 11/8/23. The home did not report the medication error to the resident's prescriber.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Audit tool is now in place for our medication dashboard electronic mar to make sure no meds are being missed they're as wellbeing prescribed.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
The home will notify resident #8's prescriber and the resident's designated person for the medication that was not available to administer from 11/4/23 to 11/8/23. In the future, the home will ensure that all

188b - Medication Error Reporting (continued)

medication errors are reported to the Department, the resident, the resident's designated person and the prescriber. The home will conduct an audit of all resident's medication errors and notify the resident's designated person and prescriber. The administrator will be responsible to conduct quarterly audits.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 03/28/2024)

188c - Medication Error Documentation

10. Requirements

2600.
188.c. Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

Description of Violation

Resident #8 is prescribed hydrocodone-acetaminophen 5-325mg 1tab-2x daily. The medication was not available to administer from 11/4/23 to 11/8/23. The home does not have documentation that the error was documented in the resident's record.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Audit tool is now in place for our medication dashboard electronic mar to make sure no meds are being missed they're as wellbeing prescribed.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
Documentation will be kept as required by this regulation. The administrator will audit the home's medication error within 10 days of receipt. Resident #8's documentation of medication errors and the prescriber's response shall be kept in the resident's record. The home will train all medication staff in documentation of medication errors and the prescriber's responses that shall be kept in the resident's record. The administrator will audit all medications errors on a monthly basis for prescriber's response.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 03/28/2024)

224a - Preadmission Screen Form

11. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted on [redacted]/23. The prescreen for resident #1 was completed on the same day of admission. Repeat violation: 5-31-23, 8-18-23.

224a - Preadmission Screen Form *(continued)*

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Marketing director as well administrator is responsible to make sure the task is completed before and prior to admission.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
The home will ensure that all residents admitted after the date shown have a preadmission screening completed. The administrator will ensure that the preadmission screening is accurate and completed in its entirety, including signing and dating the screening form. If the home determines that the resident's needs cannot be met by the home based on the preadmission screening, the home will refer the resident to the appropriate local assessment agency. The administrator will audit all resident's preadmission Screening are accurate and completed in its entirety.

Directed Completion Date: *12/22/2023*

Implemented [redacted] - 03/28/2024)

225a - Assessment 15 Days

12. 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 Initial RASPs for the following residents are not dated to indicate when the assessments were finalized:
• Resident #1 admitted [redacted]/23.
• Resident #2 admitted [redacted]/23.
• Resident #11 admitted [redacted]/22.
Resident #3 was admitted on [redacted]23. Their Initial RASP is dated 7/1/23 and not finalized within 15 days of admission.
Resident #4 was admitted on [redacted]/23. Their Initial RASP is dated 9/22/23 and not finalized within 15 days of admission.
An Initial RASP has not been completed for Resident #5, admitted 8/23/23.
An Initial RASP has not been completed for Resident #6 admitted 9/27/23.
Repeat violation: 5-31-23, 8-18-23.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

This will be put in place as long as following company's new audit tool.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
Residents #1, #2, #3, #4, and #11 will have a detailed, comprehensive assessment that identifies all of the resident(s)'s personal care needs. The assessment(s) will be documented on the Department's required form. Forms will be filled out in their entirety, including signatures and dates. The administrator will audit all resident's RASPs. The administrator will develop a system to ensure that all assessments are done correctly, completely, and within the time frames required by this Chapter.

225a - Assessment 15 Days *(continued)*

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 04/16/2024)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

An Annual RASP was not completed for the following residents:
• Resident #16; last RASP completed on 3/21/22.
• Resident #11; last RASP completed on 10/3/22.
• Resident #17; last RASP completed on 3/31/22.
• Resident #18; last RASP completed on 9/29/22.
Repeat violation: 5-31-23, 8-18-23.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

All new reportable or behavior changes will be automatically updated in the resident's rasp.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
Residents #11, #16, #17, and #18 will have a detailed, comprehensive assessment that identifies all of the resident(s)'s personal care needs. The assessment(s) will be documented on the Department's required form. Forms will be filled out in their entirety, including signatures and dates. The administrator will develop a system to ensure that all assessments are done correctly, completely, and within the time frames required by this Chapter. The Administrator will audit all residents' assessments. The assessments will be detailed, comprehensive, and filled out in their entirety, including signatures and dates.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 04/11/2024)

227c - Support Plan Revision

14. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #7 was admitted on [redacted]/23. A RASP was completed on 10/25/23 due to a significant change. The RASP is not dated to indicate when the assessment was finalized.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Resident 7 rasp has been updated and all parties are aware of the update. Moving forward this part of PSL audit tools.

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:

227c - Support Plan Revision (continued)

Resident #7 will have a detailed, comprehensive support plan that identifies exactly how the home plans to meet the resident(s)'s needs. The support plans will be completed on the Department's required form. Forms will be filled out in their entirety, including signatures and dates. The administrator will audit all residents RASPs to ensure that all support plans are done correctly, completely, and within the time frames required by this Chapter. The administrator will develop a system to ensure that all support plans are done correctly, completely, and within the time frames required by this Chapter.

Directed Completion Date: *12/22/2023*

Implemented [redacted] - 03/28/2024)

227d - Support Plan Medical/Dental

15. 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

Resident #7 had an altercation with another resident. Resident #7's assessment and support plan indicates that Resident #7 does not have a problem with aggression. Additionally, the sections about dental need and dietary need are not addressed.
Repeat Violation 11-3-22.

Plan of Correction ***Directed [redacted] - 12/11/2023)***

Resident 7 rasp has been updated and completed to meet where is currently at. All documentation has been seen by dhs on their visit on 12/4

Proposed Overall Completion Date: 12/08/2023.
Within 10 days of receipt of this directed plan of correction and ongoing:
The support plan of Resident #7 will be updated to show current behaviors. The Administrator will check all resident RASP's weekly to ensure necessary changes related to medical, dental, vision, hearing, mental health and/or behavioral health are documented in the record within 5 days of the change. The administrator will keep records of these weekly audits and provide them to the department upon request. The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *12/22/2023*

Not Implemented [redacted] - 03/28/2024)