

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

January 24, 2024

[REDACTED]  
SUGAR CREEK REST LIMITED PARTNERSHIP  
[REDACTED]  
[REDACTED]

RE: QUALITY LIFE SERVICES - SUGAR  
CREEK  
109 PERSONAL CARE LANE  
WORTHINGTON, PA, 16262  
LICENSE/COC#: 42681

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/12/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *QUALITY LIFE SERVICES - SUGAR CREEK* License #: *42681* License Expiration: *03/29/2024*  
 Address: *109 PERSONAL CARE LANE, WORTHINGTON, PA 16262*  
 County: *ARMSTRONG* Region: *WESTERN*

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: *SUGAR CREEK REST LIMITED PARTNERSHIP*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *12/01/2003* Issued By: *Worthington TWP*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *21* Waking Staff: *16*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *12/12/2023*

**Inspection Dates and Department Representative**

12/12/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: *47* 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: *0* Are 60 Years of Age or Older: *18*  
 Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *1*  
 Have Mobility Need: *3* Have Physical Disability: *0*

**Inspections / Reviews**

12/12/2023 - Full  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/05/2024*

Inspections / Reviews (*continued*)

01/19/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/19/2024

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 01/31/2024

01/24/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/19/2024

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On [REDACTED] at 10:15 a.m., the home's licensing inspection summary, dated [REDACTED], was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept [REDACTED] 01/19/2024)

1. The first 3 pages of the licensing inspection summary from the 2022 survey were posted in a binder in a public location but did not include the corrected violations from the 2022 survey. While on site, DHS surveyor educated PC Administrator where to locate the HIPAA compliant public survey results. This was printed and added to the binder during the survey on 12/12/23.
2. Verbal education was provided by DHS surveyor to PC Administrator on 12/12/23 where to locate HIPAA compliant public survey results on DHS website. PC Administrator educated PC staff on 12/28/23 on placement of survey binder in public area. Documentation of the education will be kept.
3. PC Administrator will print and post all future licensing inspection summaries received from DHS in the survey binder in a public location.
4. Audits will be completed by PC Administrator or designee 1 time per week for 4 weeks beginning on 1/8/24 and continuing through 2/2/24 to ensure binder is placed in public location and has full contents of licensing inspection summary.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] 01/24/2024)

65f - Training Topics

2. Requirements

2600.

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

1. Medication self-administration training.

Description of Violation

Direct care staff person A hired [REDACTED] did not receive training in medication self-administration during the [REDACTED] to [REDACTED] annual staff training year.

Plan of Correction

Accept [REDACTED] - 01/19/2024)

1. Staff person A is a CNA/PC Aide and is not a Med Tech. [REDACTED] transitioned from skilled care to PC on [REDACTED]. [REDACTED] was assigned to trainings by HR based on [REDACTED] title and had not been assigned the required medication self-administration training. PC Administrator verified with HR on [REDACTED] that Staff person A job title and assigned trainings had been updated in January 2023 for the 2023 training year to include all required trainings.
2. Education was provided by PC Administrator to PC staff on 12/28/23 on the DHS required annual training topics. Documentation of the education will be kept.
3. PC Administrator educated corporate education scheduler on 12/28/23 on the DHS annual required training topics for all PC staff to prevent future omissions in required education.
4. Monthly audits of employee records will be completed by PC Administrator or designee 1 time per month for 6

65f - Training Topics (continued)

months beginning 1/1/24 and continuing through 6/30/24 to ensure staff compliance in completion of trainings and compliance with required training topics.

5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] 01/24/2024)

65g - Annual Training Content

3. Requirements

2600.

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

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

Description of Violation

Direct care staff person A hired [REDACTED] did not receive training in fire safety conducted by a fire safety expert during the [REDACTED] to [REDACTED] annual staff training year.

Plan of Correction

Accepted [REDACTED] 01/19/2024)

1. Staff person A transitioned from skilled facility to PC on [REDACTED]. [REDACTED] completed the PC orientation at that time, including education on the evacuation process, and education on the smoke detectors, fire extinguishers, and use of telephones for an emergency. Staff person A was trained by another PC staff person, who is not a fire safety expert. Staff person A did have fire safety training in 2023 with a fire safety expert.
2. Education was provided by PC Administrator to PC staff on 12/28/23 on the DHS required annual training topics, including fire safety training. Documentation of the education will be kept.
3. Annual fire safety training is scheduled by the Maintenance Director and is conducted with the local fire department chief and will be made mandatory for all staff when this training is scheduled.
4. Monthly audits of employee records will be completed by PC Administrator or designee 1 time per month for 6 months beginning 1/1/24 and continuing through 6/30/24 to ensure staff compliance in completion of annual fire safety training.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] - 01/24/2024)

65i - Training Record

4. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of initial direct care staff training and orientation for staff person B, hired [REDACTED], does not include the dates the trainings were completed.

65i - Training Record (continued)

Plan of Correction

Accept (SQ - 01/19/2024)

1. Staff person B was hired on [REDACTED] and began [REDACTED] initial training on [REDACTED]. [REDACTED] remaining required orientation training was completed within the first 40 hours worked. PC Administrator consulted with Staff person B and the staff person who conducted the training. Dates of training were verified and added to the training record by PC Administrator on [REDACTED], per instruction of DHS surveyor. A note was added to the training record regarding this citation, per instruction of DHS surveyor.
2. Education was provided by PC Administrator to PC staff on 12/28/23 on the process for completion of the required initial training on the date of hire and within the first 40 hours worked. Documentation of the education will be kept.
3. New hire training will be conducted by the PC Administrator or designee with immediate review of the training record for thoroughness of documentation.
4. Monthly audits will be completed by PC Administrator or designee for new hires 1 time per month for 6 months beginning 1/1/24 and continuing through 6/30/24 to ensure compliance in completion of initial training.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] - 01/24/2024)

81a - Accomodation

5. Requirements

2600.

81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The circular assistive device attached to resident [REDACTED] bed is used to assist the resident in transferring in and out of bed and turning/positioning while in bed. However, the device moves up and down on the bed approximately 6-8 inches when grabbed from bedside and the mattress lifts approximately 4-6 inches from the frame when used at bedside creating a fall hazard for the resident.

Plan of Correction

Accept [REDACTED] 01/19/2024)

1. Resident [REDACTED] was re-assessed by PC Administrator on [REDACTED] while transferring in/out of bed and while repositioning self in bed. [REDACTED] continues to use the bedside mobility device to stabilize herself when getting into the bed, by applying downward weight through the device with no lifting of the mattress, and supports herself with the device when repositioning and transferring from supine to sitting. Resident [REDACTED] alert & oriented x 3 and reported [REDACTED] feels the device assists [REDACTED] to transfer safely and desires the device to remain on [REDACTED] bedside. On [REDACTED], PC Administrator attached an additional strap from the bedside mobility device directly downward and attached to the bed frame on the same side of the bed. The addition of this strap prevents the mattress from lifting when grabbed from bedside.
2. Education was provided by PC Administrator to PC staff on 12/28/23 on the proper use of bedside mobility devices. Documentation of the education will be kept.
3. PC Administrator or designee will continue weekly audits to monitor Resident [REDACTED] bedside mobility device for secure attachment, safe functioning, use of the covering over the opening, and continued need by the resident. Any future use of devices will be assessed and monitored by the PC Administrator or designee.
4. Audits will be completed by PC Administrator or designee 1 time per week beginning 1/1/24 and continuing

81a - Accomodation (continued)

indefinitely to ensure proper use of bedside mobility device and resident safety.

5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented (b) (6) 01/24/2024)

85d - Trash Receptacles

6. Requirements

2600.

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

Description of Violation

At (b) (6) there was a 1/2 full, uncovered trash can in the staff bathroom in the Butler wing of the home.

Plan of Correction

Accepted (b) (6) 01/19/2024)

1. The bathroom with signage for staff use had a missing lid. A lid was replaced on the trash can by the PC Administrator on (b) (6).
2. Education was provided by PC Administrator to PC staff on 12/28/23 with instruction to maintain placement of the lid on the trash can at all times. Documentation of the education will be kept.
3. Non-compliance with use of the trash can lid was the result of the lid being battery operated with need to frequently replace the batteries. A new trash can that does not require batteries was requested on 12/28/23, ordered on 1/5/23, and awaiting arrival to replace the existing trash can in the employee bathroom.
4. Daily audits will be conducted by the PC Administrator or designee 5 times per week for 4 weeks beginning on 1/8/23 and continuing through 2/2/23 to monitor for compliance with placement of the trash can lid.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented (b) (6) - 01/24/2024)

85e - Trash Outside Home

7. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At (b) (6) trash and debris were on the ground around the 55-gallon trash can directly outside of the kitchen's rear exit door.

Plan of Correction

Accepted (b) (6) 01/19/2024)

1. The trash on the ground around the trash can was picked up immediately after being observed on 12/12/23 by maintenance staff and placed in covered trash can.
2. Education was provided by PC Administrator to PC staff and ancillary staff on 12/28/23 that all outside trash must be kept in a covered receptacle, which is to be the dumpster. Documentation of the education will be kept.
3. The outside trash can was removed from the rear kitchen exit door area on 12/12/23. Only the dumpster will be utilized for placement of trash.

85e - Trash Outside Home (continued)

- 4. Audits will be completed by PC Administrator or designee 1 time per week for 4 weeks beginning on 1/8/24 and continuing through 2/2/24 to ensure proper placement of outside trash.
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] - 01/24/2024)

86b - Bathroom

8. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom outside of Administrator's office in the Armstrong wing of the home did not have an operable window or ventilation fan. The ventilation fan was inoperable and there was no window in the bathroom.

The bathroom nearest to the dining room in the Butler wing of the home did not have an operable window or ventilation fan. The ventilation fan was inoperable and there was no window in the bathroom.

Plan of Correction

Accept [REDACTED] - 01/19/2024)

- 1. Maintenance Director assessed the Armstrong and Butler hallway bathroom vents for proper function on [REDACTED]. Determined vents were only operating when the furnace was running in the common areas. Electrician was contacted on 12/28/23 and scheduled for 1/4/24 to make repairs. Repairs to bathroom vents were finalized on 1/4/24 by the electrician.
- 2. Education provided by Administrator to Maintenance Director and maintenance staff on Regulation 2600.86.b. Documentation of the education will be kept.
- 3. Repairs were made to faulty bathroom vents by licensed electrician during site visit on 1/4/24 and will be maintained for proper working condition by Maintenance Director or designee.
- 4. Monthly audits will be conducted by the Maintenance Director or designee beginning 1/8/24 and continuing indefinitely with 1 audit per calendar month to ensure proper functioning of bathroom vents.
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] - 01/24/2024)

87 - Lighting

9. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

At [REDACTED] the exterior walkway light immediately outside the rear exit of the kitchen was not operable.

Plan of Correction

Accept [REDACTED] 01/19/2024)

- 1. During the survey, it was identified that the light bulb was burnt out, outside the rear exit of the kitchen. This is not an area or exit utilized by residents. The bulb was immediately replaced by maintenance staff during the

87 - Lighting (continued)

inspection on 12/12/23.

2. Education was provided by PC Administrator to PC staff and ancillary staff on 12/28/23 to monitor lamps and lights for extinguished bulbs and to replace such bulbs immediately, or to submit a maintenance request for repairs if unable to complete without assistance.

3. General use standard sized light bulbs have been made available to PC staff for replacing lamp bulbs and easily accessed lights on 12/13/23. The login information for submitting a maintenance request was placed on a bulletin board for employee reference on 12/13/23.

4. Audits will be conducted by the PC Administrator or designee 1 time per week for 4 weeks beginning 1/1/24 and continuing through 1/26/24 and then monthly audits for 3 months beginning on 2/1/24 and continuing through 4/30/24 to monitor for safe lighting.

5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [redacted] 01/24/2024)

105g - Lint Removal and Duct Cleaning

10. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At [redacted] there was an approximate 1/4-inch accumulation of lint on the lint screen of the dryer near the window in the laundry room.

Plan of Correction

Accept [redacted] - 01/19/2024)

1. The lint was cleaned from the dryer lint trap immediately upon observation on 12/12/23 by PC staff.

2. Education was provided by PC Administrator to PC staff on 12/28/23 to clean lint from the dryer lint trap after each use of the dryer, rather than prior to beginning a new load, as had been the practice.

3. A bright colored laminated sign was affixed to the top of the dryer stating "Clean Lint Trap after Each Use" on 12/28/23.

4. Audits will be completed by the PC Administrator or designee 5 times per week for 2 weeks beginning on 1/1/24 and continuing through 1/12/24 and 1 time per week for 4 weeks beginning 1/15/24 and continuing through 2/9/24 to ensure compliance with cleaning the lint trap.

5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [redacted] - 01/24/2024)

183b - Meds and Syringes Locked

11. Requirements

2600.

183b - Meds and Syringes Locked (continued)

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

At [redacted] three 2oz tubes of [redacted] belonging to resident [redacted] were unlocked, unattended and accessible in the bathroom near the dining room on the Butler wing side of the home.

Repeat Violation: 12/20/22 et al.

Plan of Correction

Accept [redacted] - 01/19/2024)

1. The three tubes of [redacted] located in the common bathroom cabinet were immediately removed and disposed of on 12/12/23 by PC staff.
2. Education was provided by PC Administrator to PC staff on 12/13/23 regarding Regulation 2600.183.b requirements. Documentation of the education will be kept.
3. PC staff were educated on proper storage of medications on 12/13/23. New hires will be educated by PC Administrator or designee on proper storage of medications during initial orientation.
4. Audits will be completed by PC Administrator or designee 1 time per week for 4 weeks beginning 1/1/24 and continuing through 1/26/24 and then monthly audits for 3 months beginning on 2/1/24 and continuing through 4/30/24 to monitor for proper storage of medications and ensure ongoing compliance with regulation.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [redacted] - 01/24/2024)

185a - Implement Storage Procedures

12. 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 [redacted] is prescribed [redacted] readings twice per day. The resident's [redacted] serial number [redacted] [redacted] indicated a [redacted] on [redacted] and [redacted] at [redacted] however, neither reading was documented on the resident's December 2023 medication administration record.

Plan of Correction

Accept [redacted] 01/19/2024)

1. Routine [redacted] readings were obtained as ordered on [redacted] at [redacted] to be [redacted] and on [redacted] at [redacted]. Due to low readings on both days, the PC Med Tech repeated a prn [redacted] reading after resident completed breakfast and documented these [redacted], listed above, in the documentation system under the resident's Weights/Vitals tabs, per facility protocol. The prn readings do not carry over to the MAR because the routine order does not include the prn order. The order was updated, per physician order, to include a prn order for [redacted].
2. Education was provided by PC Administrator to PC staff on 1/3/23 to document prn blood sugar readings under the prn order in the MAR.
3. New PC staff hires will be educated by PC Administrator or designee on the blood sugar reading documentation process during initial orientation and will be followed-up after completion of med tech training.
4. Audits will be completed by PC Administrator or designee 1 time per week for 4 weeks beginning 1/1/24 and continuing through 1/26/24 and then 1 time per month for 3 months beginning 2/1/24 and continuing through [redacted].

185a - Implement Storage Procedures (continued)

4/30/24 to monitor for compliance with blood sugar documentation process.

5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] 01/24/2024)

225a - Assessment 15 Days

13. 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 [REDACTED] was admitted on [REDACTED]; however, the resident's initial assessment was not completed until [REDACTED].

Plan of Correction

Accepted [REDACTED] 01/19/2024)

1. PC Administrator did not count day of admission as day 1, but rather day 0, therefore the initial assessment was completed 1 day late. The error in the date was corrected and a note was documented on the initial assessment regarding the cited violation on 12/13/23, per instruction of the DHS surveyor.

2. PC Administrator was provided verbal education on 12/12/23 during the survey by the DHS surveyor that day of admission is day 1.

3. The PC Administrator electronic process for tracking due dates of initial assessments was updated on 12/13/23 to reflect day of resident admission as day 1.

4. All assessments are completed by the PC Administrator. No additional audit is indicated as the process has been corrected.

5. Results of the violation intervention will be reviewed in monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 02/05/2024

Implemented [REDACTED] 01/24/2024)