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

May 21, 2024

ALLIED SERVICES PERSONAL CARE INC

RE: ALLIED SERVICES MEADE STREET RESIDENCE
260 SOUTH MEADE STREET
WILKES-BARRE, PA, 18702
LICENSE/COC#: 22812

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/01/2024, 02/05/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ALLIED SERVICES MEADE STREET RESIDENCE* **License #**: *22812* **License Expiration**: *10/02/2024*

Address: *260 SOUTH MEADE STREET, WILKES-BARRE, PA 18702*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *ALLIED SERVICES PERSONAL CARE INC*

Address: *100 ABINGTON EXECUTIVE PARK, CLARKS SUMMIT, PA, 18411*

Phone: *5703481329* **Email**: *JCOONE@ALLIED-SERVICES.ORG*

Certificate(s) of Occupancy

Type: *C-1* **Date**: *03/16/2011* **Issued By**: *Wilkes Barre City*

Type: *C-2 LP* **Date**: *08/24/1998* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *69* **Waking Staff**: *52*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *02/13/2024*

Inspection Dates and Department Representative

02/01/2024 - On-Site:

02/05/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *76* **Residents Served**: *54*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *terrace level* **Capacity**: *15* **Residents Served**: *15*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *54*

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

Have Mobility Need: *15* **Have Physical Disability**: *0*

Inspections / Reviews

02/01/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/16/2024*

Inspections / Reviews *(continued)*

03/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/14/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/02/2024*

04/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/14/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/14/2024*

05/21/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/14/2024*

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

15c - Supervision

1. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted] an incident was reported to the department alleging mistreatment of Resident [redacted] by Staff Member A. Staff member A was suspended; however a plan of supervision was not submitted to the Department for the return of Staff member A after an allegation of abuse was made by Resident [redacted]

Plan of Correction ***Accept [redacted] - 04/04/2024)***

Administrator immediately submitted a plan of supervision to DHS on [redacted] and was approved on [redacted] before staff member A returned to next scheduled shift.
The Administrator/Assistant Administrator are responsible for submitting plan of supervision to DHS for approval prior to staff member returning to work when investigating allegations of abuse.
The Administrator/Assistant Administrator will monitor allegations of abuse to ensure timely submission of plans of supervision prior to staff member returning to work. Administrator will review any/all reportable events weekly to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented ([redacted] - 05/03/2024)

16c - Written Incident Report

2. 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

An incident occurred on [redacted] between staff member A and Resident [redacted]. Through interviews with the administrator and staff it was determined that the incident occurred during morning care around 6:30am. The incident report notes the incident occurred on [redacted] at 1:45pm and was reported on [redacted] at 12:45 pm. The incident was reported greater than 24 hours after the incident occurred.

Resident [redacted] left the facility on [redacted] at 120am. The staff were made aware [redacted] left the building when [redacted] was returned approximately 310am on [redacted] by Emergency Services. An incident report was not created.

Plan of Correction ***Directed [redacted] - 04/04/2024)***

LPN Supervisor was immediately in-serviced by Administrator on abuse reporting timeline.
All DCS will be in-serviced by Administrator by 3/21/24 on OAPSA to ensure timely reporting of abuse.
Staff will be re-educated on OAPSA every 6 months to ensure compliance.
Administrator/Assistant Administrator are responsible to timely report Incident reports to DHS in the event a resident is returned to the facility by EMS.
Administrator/Designee will monitor allegations of abuse and incidents to ensure timely reporting to DHS. Reports will be reviewed weekly to ensure compliance.

Proposed Overall Completion Date: 04/02/2024

16c - Written Incident Report (continued)

(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: *04/14/2024*

Implemented (█ - 05/03/2024)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident █ walked out of the facility at approximately 120am on █. The resident was returned to the facility at approximately 310am by local Emergency Services (ambulance). Resident █ Resident Assessment Plan dated █ - █, states the resident is to be accompanied when in unfamiliar surroundings, outings to ensure safety, and has every 2 hour checks. The facility did not meet the need of the resident in the morning hours of █ when the home did not complete the 230am bed check for Resident █.

Plan of Correction ***Accept (█ - 04/04/2024)***

Residents requiring 2-hour safety checks will have staff sign off sheets in room to ensure completion of rounds.
Assistant Administrator will update resident RASPs accordingly in the event a resident requires 2-hour safety checks.
Assistant Administrator will review safety check sign off sheets weekly.
Administrator will audit Assistant Administrators safety check sign off sheets. The results of these audits will be reviewed in quarterly QA to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented (█ - 05/03/2024)

58a - Awake Staff 16 or More

4. Requirements

2600.
58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

According to staff interviews, Staff Member B was found sleeping during █ shift at approximately 310am on █, when other staff went looking for █ to make █ aware of a resident elopement.

Repeated violation 7-27-23

58a - Awake Staff 16 or More *(continued)*

Plan of Correction ***Accept - 04/04/2024)***

Staff member B was immediately verbally in-serviced by Administrator on regarding the importance of remaining awake while on duty. Regulation 58a was reviewed and staff member verbalized understanding of the same.
There were 4 staff members on duty the night of which exceeds regulatory staffing guidelines.
Staff member B has since resigned from position at this facility.
All staff will be in-serviced by Administrator on Regulation 58a. by 3/21/24.
Overnight security to perform nightly rounds to ensure all staff are awake and available during their shift.
Monthly sign off sheet to be provided by security and reviewed by Assistant Administrator.
Administrator will audit monthly security sign off sheet. The results of these audits will be

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented - 05/03/2024)

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident’s assessment and support plan.

Description of Violation

On , Staff Member B arrived at work at 1230am on leaving 3 staff to evacuate 38 Personal Care residents and 14 Secure Dementia Care Unit (SCDU) residents for 1 hour (from 1130pm on to 1230am on . This is the night Resident left the facility and was returned to the facility by Emergency Services.
On Staff Member B arrived at work at 1:42am on , leaving 2 staff to evacuate 38 Personal Care residents, and 14 Secure Dementia Care Unit (SDCU) residents for 2 hours and 12 minutes (from 1130pm on to 142am on), and leaving an inability to meet the needs of the residents, if evacuation is needed.

On , Staff Member B arrived at work 12:41am on , leaving 2 staff to evacuate 38 PC residents, and 14 SCDU residents for 1 hour and 11 minutes (from 1130 pm on to 1241am on), and leaving an inability to meet the needs of the residents, if evacuation is needed.

On , Staff member B arrived at work at 11:37 pm, leaving 2 staff to evacuate 38 PC residents and 14 SCDU residents for 7 minutes, and leaving an inability to meet the needs of the residents, if evacuation is needed.

On , Staff Member B arrived at work at 11:57pm, leaving 2 staff to evacuate 37 PC residents and 14 SCDU residents for 27 minutes, and leaving an inability to meet the needs of the residents, if evacuation is needed.

On Staff Member B arrived at work at 11:34pm, leaving 2 staff to evacuate 36 PC residents and 14 SCDU residents for 4 minutes, and leaving an inability to meet the needs of the residents, if evacuation is needed.

Repeated Violation 7-27-23

Plan of Correction ***Directed - 04/04/2024)***

After calculating staffing ratios, it was determined by the Administrator that on 3 staff were in the building

60a - Staff/Support Plan (continued)

until staff member B arrived which meets staffing regulations per DHS guidelines, even though staff member B did not report to work until 12:30am.
All 3-11 staff members were immediately verbally in- serviced by Administrator on [redacted] to ensure scheduled staff members are on-site before exiting the building. Staff will notify Administrator/Assistant Administrator if any 11-7 staff do not arrive for scheduled shift.
Staff B has since resigned from this facility.
Assistant Administrator is responsible for staff scheduling and will ensure that the staffing schedule meets regulatory guidance.
Administrator will review staff schedule weekly for compliance and review results in quarterly QA meetings.

Proposed Overall Completion Date: 04/02/2024

(Directed)
Effectively immediately and ongoing the Administrator will review the schedules to ensure at least 3 staff members are always working from 11p-7am, and adjust staffing ratio's according to the residents needs immediately as they change. The Administrator will review timecards for the 11p-7am shift weekly to ensure staff members are present in the building for the entire shift for 4 weeks. Documentation of these audits and findings will be kept for the Department for review upon request.

Directed Completion Date: *04/09/2024*

Implemented [redacted] - 05/03/2024)

121a - Unobstructed Egress

6. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The front entrance door has a lock to prevent unauthorized egress. The button to disengage the lock does not work properly, preventing immediate egress in the event of an emergency. Interviews with staff indicated that staff member B would lock the front doors on [redacted] shift to keep the residents in.

Plan of Correction ***Directed [redacted] - 04/04/2024)***

At time of inspection, the lock at the front entrance door was deactivated and removed by maintenance.
Maintenance to ensure immediate egress of main door monthly with unannounced fire drills.
Administrator/Assistant Administrator will be made aware immediately by maintenance if there are any issues with egress.
Administrator will review monthly fire drill reports to ensure compliance and review reports in quarterly QA meetings.

Proposed Overall Completion Date: 04/02/2024

(Directed)
Effective immediately and ongoing the identified area will be unobstructed and unlocked, as will all

121a - Unobstructed Egress (continued)

stairways, hallways, doorways, passageways and egress routes from rooms and from the building. The Administrator will conduct a training with all staff regarding this regulation. The home will audit all egress routes weekly for 4 weeks and periodically after. Documentation of the training and audits completed will be kept for the Departments review upon request.

Directed Completion Date: *04/09/2024*

Implemented - 05/03/2024)

183a - Original Containers and Injections

7. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Per staff interviews, Staff Member B would prepare 6am medications at the beginning of the shift, allowing pre-poured medication to sit on the medication cart, unlocked and unattended for hours until the 6am medication pass.

Plan of Correction ***Accept 04/04/2024)***

Assistant Administrator will retrain all med certified staff by on the importance of keeping all medications in their original container/packaging until time of administration according to MAR.
Assistant Administrator will conduct quarterly med pass audits with med certified staff to ensure medication passes are being completed according to resident MAR.
Administrator will review Assistant Administrators medication observation documentation. These results will be reviewed in quarterly QA meetings to ensure compliance.
Staff member B has since resigned from this facility.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented 05/03/2024)

227d - Support Plan Medical/Dental

8. 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 left the facility on at 120am and was returned to the facility by Emergency Services on at 310am. The Resident Assessment and Support Plan was not updated regarding the incident.

Resident was involved in an incident with a staff member and sustained a skin tear which necessitated a bandage which needed to be changed regularly. The Resident Assessment Support Plan dated was not updated to document the incident, the resident's skin tear sustained during the incident and care needed to maintain the injury.

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

Plan of Correction ***Accept - 04/04/2024)***

Resident RASP was immediately updated by Assistant Administrator at time of inspection to reflect wandering behavior.
Assistant Administrator was in-serviced by Administrator on regarding the importance of updating a resident RASP due to significant changes in resident behavior.
Administrator will review reports of significant changes in resident behavior to ensure RASP has been updated to reflect the resident needs. The results will be reviewed in quarterly QA meetings to ensure compliance.

Resident RASP was immediately updated by Assistant Administrator at the time of inspection to reflect treatment of skin tear.
Assistant Administrator was in-serviced by Administrator on on updating the resident RASPs to reflect the current treatment of skin tear and documentation of incidents that sustain injury.
Administrator will audit monthly I&A reports to ensure incidents that sustain injury to the resident are documented and treatments to injuries are updated in the residents' plan of care. The results will be reviewed in quarterly QA meetings to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented (- 05/21/2024)