

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

March 14, 2024

[REDACTED], ADMINISTRATOR
SAYRE MEMORY CARE RESIDENCE LLC
[REDACTED]
[REDACTED]

RE: SAYRE MEMORY CARE RESIDENCE
1001 NORTH ELMER STREET
SAYRE, PA, 18840
LICENSE/COC#: 23082

Dear [REDACTED],

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

[REDACTED]
Acting Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: SAYRE MEMORY CARE RESIDENCE License #: 23082 License Expiration: 02/01/2025
 Address: 1001 NORTH ELMER STREET, SAYRE, PA 18840
 County: BRADFORD Region: NORTHEAST

Administrator

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

Legal Entity

Name: SAYRE MEMORY CARE RESIDENCE LLC
 Address: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 09/05/2015 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 44 Waking Staff: 33

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 02/01/2024

Inspection Dates and Department Representative

02/01/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 46 Residents Served: 22

Secured Dementia Care Unit
 In Home: Yes Area: entire building Capacity: 46 Residents Served: 22

Hospice
 Current Residents: 2

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 22
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 22 Have Physical Disability: 0

Inspections / Reviews

02/01/2024 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/03/2024

03/04/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 03/14/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/11/2024

Inspections / Reviews *(continued)*

03/07/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/14/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/14/2024

03/14/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/14/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 - Record Confidentiality

1. 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

During initial walk through, the door to the nurse's station was left open, leaving resident records accessible.

Plan of Correction

Accept (█) - 03/05/2024)

On 2/1/2024, during the inspection walk-through of the facility for our annual survey, resident's hot file chart was located on nursing station and gate was unlocked.

Violation corrected immediately during the walk through when a PCA grabbed the hot file chart and placed in room where residents' charts are locked.

Who: The Administrator or Director of Wellness will train all staff on Plan of Correction- Record Confidentiality and complete sign in sheet.

When: Training completed on 2/2/2024.

How: Administrator or Director of Wellness will assure all residents records are kept locked up.

Ongoing: The Director of Wellness will complete daily checks to ensure all residents charts are locked up if unsupervised. The Administrator and/or Director of wellness will conduct a weekly audit on every Wednesday of the nursing area to assure confidentiality of resident records are in place for ongoing compliance. Results will be documented in Administrators office in the Audit Binder. Findings and trends will be reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented (█) - 03/14/2024)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The required influenza information, in accordance with the Influenza Awareness Act, was not posted in the home.

Plan of Correction

Accept (█) - 03/05/2024)

Violation: The required influenza information, in accordance with the Influenza Awareness Act, was not posted in the home.

To fix: Administrator printed off the Influenza poster and hung at nurses station on 2/1/2024 during onsite inspection.

To ensure on going compliance, Administrator will complete weekly walk through to ensure all mandatory postings are visible and hanging in a conspicuous space.

Licensee's Proposed Overall Completion Date: 03/05/2024

Implemented (█) - 03/14/2024)

25c6 - Refunds

3. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

- 6. The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

Description of Violation

The record of resident #1 did not contain the home's refund policy. The contract was missing page 2 which is the page of the contract that addresses refund policy.

Plan of Correction

Accept [redacted] - 03/04/2024)

Page 2 in contract was placed in resident chart by Administrator.

Administrator and Director of Welness will complete monthly chart audits to ensure on going compliance.

Administrator gave family a new copy 2/2/2024.

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented ([redacted] - 03/14/2024)

64c - Annual Training

4. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

The administrator does not have 24 hours of annual training. Upon investigation, only 11.25 hours of training could be verified for the training year September 2022 – August 2023.

Plan of Correction

Accept [redacted] - 03/05/2024)

Clarification as to what is approved website CEU's given to this Administrator by onsite inspectors on 2/1/2024. This Administrator will complete all department approved CEU's to be compliant with state regulations for the upcoming training year (9/1/2023 to 8/31/2024) including 12.75 hours from 9/1/2022 to 8/31/2023. Administrator is scheduled with all of Temple and Northampton courses being offered. 3/20/2024 scheduled. Collins Learning trainings will be completed . Administrator will complete 36.75 training hours including previous year and current year to follow regulation 2600.64c by 8/31/2024 to follow training plan.

Regional Administrator will oversee all trainings are completed in the time frame.

Licensee's Proposed Overall Completion Date: 03/05/2024

Implemented ([redacted] - 03/14/2024)

82c - Locking Poisonous Materials

5. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

82c Locking Poisonous Materials (continued)

Dermasil Cocoa Butter lotion was located in the activities room storage closet with a manufacture's label indicating if accidental ingestion, seek professional assistance or contact poison control immediately. The closet was unlocked, unattended, and accessible to residents. All the residents of the home have been assessed as incapable of recognizing and using poisons safely.

Plan of Correction

Accept () - 03/05/2024)

To fix violation immediately, the door was locked by Administrator to comply with regulation 2600.82c during walk through inspection on 2/1/2024.

To monitor ongoing compliance, Activities Director will store any poisonous materials in locked drawer in her locked office.

Administrator will oversee ongoing compliance on daily rounds. Any findings will be documented and reported until no repeated violations.

Licensee's Proposed Overall Completion Date: 03/04/2024

Implemented () - 03/14/2024)

105g - Lint Removal and Duct Cleaning

6. 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

The home has a dryer located in the staff break area. The dryer's lint hose going from the dryer to the outside vent was obstructed due to the dryer pressing on the hose where it attaches to the wall.

Plan of Correction

Accept () - 03/04/2024)

Fixed while inspectors on site. Dryer was repositioned to reduce the obstruction of the hose. Housekeeping and caregivers will complete daily checks. Administrator will oversee on going compliance.

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented () - 03/14/2024)

121a - Unobstructed Egress

7. 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

2 bags of garbage were sitting outside the door of the dining room blocking egress. Also, a laundry cart was sitting in front of the exit door in the dual use break room/laundry room, blocking egress.

Plan of Correction

Accept () - 03/04/2024)

Fixed while inspectors were on site.

121a - Unobstructed Egress (continued)

Administrator educated staff on importance of this regulation. Staff will do daily checks on exits to ensure no obstructed egress.

see attachment

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented () - 03/14/2024

123a - Exit Doors**8. Requirements**

2600.

123.a. Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

Description of Violation

The exit door located at the loading dock would not open without excessive force used, preventing immediate egress in the event of an emergency.

Plan of Correction

Accept () - 03/04/2024

Maintenance adjusted the pins in push bar on 2/2/2024 for it too easily be opened by residents from the inside in event of an emergency. Administrator will do weekly audits of all egress on Wednesdays to ensure on going compliance.

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented () - 03/14/2024

131c - Kitchen Fire Extinguisher**9. Requirements**

2600.

131.c. A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

Description of Violation

Upon inspection of the K fire extinguisher located in the kitchen, it was found that the pressure gauge indicated the extinguisher was outside the operable range.

Plan of Correction

Accept () - 03/04/2024

On 2-12-24 Cintas replaced our K fire extinguisher. Maintenance will continue to complete monthly fire extinguisher audits. Administrator will oversee on going compliance.

See attached.

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented () - 03/14/2024

144c1 - Smoking Area Guidelines**10. Requirements**

2600.

144c1 Smoking Area Guidelines (continued)

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

Description of Violation

A wooden bench in the designated smoking area was surrounded by fallen leaves at its base. Furthermore, no fire extinguisher was found in this vicinity.

Plan of Correction

Accept () - 03/04/2024

Facility removed the bench from the smoking area on 2/1/2024 to prevent future violations. Caregivers will monitor this area on a daily basis. Maintenance and Administrator will oversee on going compliance.

see photo attached.

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented () - 03/14/2024

184a - Resident's Meds Labeled

11. 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 #2's Medication Administration Record states that resident #3 apply [redacted] as needed beginning on [redacted]. However, the medication label stated apply externally every bedtime for 30 days.

Plan of Correction

Accept () - 03/04/2024

Fixed while inspector on site. Directions change label was placed due to physicians order change. Director of wellness will complete weekly medication cart audits on Tuesdays to ensure ongoing compliance. Administrator will oversee.

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented () - 03/14/2024

187d - Follow Prescriber's Orders

12. Requirements

2600.

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

Description of Violation

On [redacted], Resident #2 did not receive as prescribed [redacted] due to medication not being available. On [redacted], Resident #3 did not receive 8pm dose of [redacted] due to medication not available. These medications were not administered as prescribed.

Plan of Correction

Accept () - 03/05/2024

To fix this violation: Administrator and Director of Wellness instituted policy for re ordering medications. Policy states medications will be reordered seven days in advance to ensure pharmacy being given ample time to obtain and deliver medications. Staff training reorder policy taught during new hire process as well as weekly med cart audits on Tuesdays.

187d - Follow Prescriber's Orders (continued)

If pharmacy unable to deliver, primary doctor is notified immediately. Orders are to be faxed with a follow up phone call to ensure orders are received.

Administrator oversees ongoing compliance with weekly audits on Wednesdays.

Licensee's Proposed Overall Completion Date: 03/05/2024

Implemented () - 03/14/2024

233c - Key-Locking Devices

13. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The home has a courtyard outside of its secured dementia unit with two gates to exit. The gates are locked by a keypad and the code to the keypad is not posted near the device.

The home has a secured dementia unit. The 200 hallway is locked by a keypad and the code to the keypad is not posted near the device.

Plan of Correction

Accept () - 03/04/2024

Corrected at time of inspection. Supervisor along with administrator will complete weekly checks on Wednesdays to ensure all doors with an egress have directions for their operation posted conspicuously near the device.

Attached to this plan of correction are pictures of the directions for 200 hall exit and courtyard gates.

Licensee's Proposed Overall Completion Date: 03/01/2024

Implemented () - 03/14/2024