

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

January 10, 2025

[REDACTED]
THOMAS SMITH
[REDACTED]

RE: COMFORTS OF HOME
1619 LISTONBURG ROAD
CONFLUENCE, PA, 15424
LICENSE/COC#: 33113

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/08/2024, 10/09/2024 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: COMFORTS OF HOME License #: 33113 License Expiration: 05/21/2025
 Address: 1619 LISTONBURG ROAD, CONFLUENCE, PA 15424
 County: SOMERSET Region: CENTRAL

Administrator

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

Legal Entity

Name: THOMAS SMITH
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other Date: 09/17/1986 Issued By: Dept of Labor & Industry

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 17 Waking Staff: 13

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint, Interim Exit Conference Date: 10/09/2024

Inspection Dates and Department Representative

10/08/2024 - On-Site: [REDACTED]
 10/09/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 18 Residents Served: 16

Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:

Hospice
 Current Residents: 0

Number of Residents Who:
 Receive Supplemental Security Income: 16 Are 60 Years of Age or Older: 13
 Diagnosed with Mental Illness: 11 Diagnosed with Intellectual Disability: 5
 Have Mobility Need: 1 Have Physical Disability: 2

Inspections / Reviews

10/08/2024 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/28/2024

01/07/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 10/28/2024
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 01/13/2025

Inspections / Reviews *(continued)*

01/10/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/10/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

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

Around [REDACTED] there was an incident of resident-to-resident abuse during which Resident [REDACTED] scratched Resident [REDACTED] on the right forearm, leaving five small marks. As of [REDACTED], this incident has not been reported to the Department.

Plan of Correction

Directed ([REDACTED] - 10/30/2024)

- The administrator and designee completed and incident report and submitted it to the department on [REDACTED]. Please see the attached incident report.
- The Administrator and designee provided education to the staff on [REDACTED] instructing them to notify the Administrator if there were any situations or allegations of any type of abuse.
- An additional training was provided to staff on [REDACTED] by the Administrator and designee. The Administrator and designee went over all types of reportable incidents in depth and explained the importance of reporting all incidents.
- The Administrator and designee will continue to monitor situations in the home and speak to residents and staff to ensure all incidents are being reported. If any incidents are found, the Administrator or designee will report them immediately.
- The Administrator will include an in depth discussion of reportable incidents during future staff trainings and at the annual Quality Management Meeting.
- Documentation of all incident reports, the staff trainings and the staff & resident discussions will be kept by the home and available for the department to review.

(Directed)

In addition to the above plan of correction, beginning no later than [REDACTED], the Administrator or designee will meet with staff on a daily basis to discuss incidents that may have occurred the day prior. The Administrator will then audit Reportable's sent to the Department to ensure timely notification.

Directed Completion Date: 10/30/2024

Implemented [REDACTED] 01/10/2025)

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

Around [REDACTED], Staff Member A was present when Resident [REDACTED] grabbed Resident [REDACTED] and scratched [REDACTED] right forearm. On [REDACTED], Resident [REDACTED] showed an agent of the Department five round scars on the right forearm, each

42b Abuse (continued)

measuring approximately 1/4" in in diameter, which [redacted] stated were the marks from Resident [redacted]. As reported by APS and Resident [redacted] there were two occasions when Resident [redacted] attacked Resident [redacted] on [redacted] and shortly before that, when Resident [redacted] grabbed Resident [redacted]'s arm but did not leave marks. The home later reported an incident to the Department on [redacted] at which time Resident [redacted] threw shoes at Resident [redacted] but did not make contact. Resident [redacted] had reported to APS and the agent that [redacted] was worried about [redacted] safety and felt vulnerable. Resident [redacted] informed the agent that [redacted] feels safer now that Resident [redacted] is no longer residing in the home.

Plan of Correction

Accept ([redacted] 10/30/2024)

- The Administrator and designee provided education to the staff on [redacted] instructing them to notify the Administrator if there were any situations or allegations of any type of abuse.
- The Administrator and Designee educated the staff on all types of abuse, including resident to resident abuse.
- The Administrator and designee will continue to monitor situations in the home and speak to residents and staff to ensure that there are not any incidents or allegations of abuse, and if there are we will ensure all incidents are being reported.
- The Administrator will include an in depth discussion of abuse during future staff trainings and at the annual Quality Management Meeting.
- Documentation of the staff trainings and the staff & resident discussions will be kept by the home and available for the department to review.

Licensee's Proposed Overall Completion Date: 10/28/2024

Implemented [redacted] - 01/10/2025)

185a - Implement Storage Procedures

3. 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

On [redacted] at 12:00PM, Resident [redacted] had a [redacted] level of [redacted] recorded on the Medication Administration Record (MAR). The glucometer reading for [redacted] at 11:57AM was [redacted].

On [redacted] at 12:00PM, Resident [redacted] had a [redacted] level of [redacted] recorded on the Medication Administration Record (MAR). The [redacted] reading for [redacted] at 12:29PM was [redacted].

On [redacted], the Individual Resident Controlled Medication Record for Resident [redacted] documented [redacted] with 20 tablets remaining. However, the blister pack only contained 19 tablets. Staff Member A reported that another staff member administered the medication to the resident that morning and [redacted] neglected to update the Individual Resident Controlled Medication Record and resident's medication administration record.

Plan of Correction

Directed [redacted] - 10/29/2024)

- On [redacted] the Controlled Medication Record for Resident [redacted] was updated by the designee and is accurate.

185a - Implement Storage Procedures (continued)

- The Administrator, designee and office staff conducted an audit of med cart on [REDACTED] to ensure all blood glucose readings and medication counts on the Controlled Medication Records were accurate. Administrator, designee and office staff will continue to audit the med cart, all documenting medication records and glucometers monthly.
- Staff were educated on [REDACTED] by the Administrator and designee on the importance of being mindful and properly documenting all blood glucose readings and medication counts on the Controlled Medication Records.
- The Administrator or designee will continue to complete monthly audits of the med cart, glucometers and Controlled Substance Records for accuracy.
- Documentation of the trainings and completed audits will be kept by the home for review by the Department.

(Directed)

In addition to the above plan of corrections:

- Beginning no later than [REDACTED], the Administrator or designee will complete weekly audits on all resident glucometers and documented blood glucose levels.
- All staff who administer medication will receive education by [REDACTED] on documenting the administration of controlled medication by the Administrator or designee.
- Beginning no later than [REDACTED], the Administrator or designee will complete weekly audits on the controlled medication and documentation of administration of the medication to ensure the amount available matches the documentation.

Directed Completion Date: 10/30/2024

Implemented [REDACTED] - 01/10/2025)

187b - Date/Time of Medication Admin.

4. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] units sub-q at bedtime, [REDACTED] take 1 tablet by mouth at bedtime, [REDACTED] inhale 2 puffs by mouth twice a day, and [REDACTED] take 2 tablets by mouth twice a day. Resident [REDACTED] medication administration record does not include the initials of the staff person who administered the above medications on [REDACTED] at 8:00PM.

Plan of Correction

Accept [REDACTED] - 10/30/2024)

- Staff were initially educated on [REDACTED] on being mindful and to make sure that they are documenting medication administration correctly by the Administrator and designee.
- An additional training was provided to staff on [REDACTED] by the Administrator and designee. Staff were reminded that omissions were medication errors and were re-educated on properly documenting a medication administration.
- Beginning [REDACTED], the Administrator or designee began performing monthly audits of the MARS to ensure that all medications administered and include the staff persons initials on the MARS.
- Documentation of the trainings and completed audits will be kept by the home for review by the Department.

187b Date/Time of Medication Admin. (continued)

Licensee's Proposed Overall Completion Date: 10/28/2024

Implemented () - 01/10/2025)

252 - Record Content

5. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

The record for Resident (), who () in the home on (), does not include a copy of the resident's official death certificate.

Plan of Correction

Directed () - 10/29/2024)

- After multiple attempts by the designee to obtain Resident () death certificate, the home finally received a copy () Please see the attached copy.
- If a resident dies in the home, the administrator and designee will continue to follow up with all parties applicable until we obtain a copy of the resident's death certificate,
- All death certificates will be available in the home for the Department to review.

(Directed)

- Beginning no later than (), the home will make immediate attempts to obtain an official death certificate for any resident who passes away while residing in the home. Attempts to obtain a resident's death certificate will be documented and kept by the home.
- Beginning no later than (), the Administrator or designee will audit a resident's chart weekly after a resident passes away until the death certificate is obtained and filed in the chat.

Directed Completion Date: 10/30/2024

Implemented () - 01/10/2025)