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

January 9, 2025

[redacted]
LIFEQUEST NURSING CENTER
[redacted]

RE: THE VILLAGE AT LIFEQUEST
2100 CHERRY BLOSSOM LANE
QUAKERTOWN, PA, 18951
LICENSE/COC#: 14496

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/06/2024, 11/07/2024 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: *THE VILLAGE AT LIFEQUEST* **License #**: *14496* **License Expiration**: *11/07/2025*

Address: *2100 CHERRY BLOSSOM LANE, QUAKERTOWN, PA 18951*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *LIFEQUEST NURSING CENTER*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/22/2019* **Issued By**: *Milford Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *137* **Waking Staff**: *103*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *11/07/2024*

Inspection Dates and Department Representative

11/06/2024 - On-Site: [redacted]

11/07/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *141* **Residents Served**: *107*

Special Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *107*

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

Have Mobility Need: *30* **Have Physical Disability**: *1*

Inspections / Reviews

11/06/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/01/2024*

12/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/08/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/09/2024*

Inspections / Reviews *(continued)*

12/12/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/08/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/09/2025*

01/09/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/08/2025*

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

16c Incident reporting

1. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] Resident [redacted] reported to Agents of the Department on site, that from [redacted] through [redacted], they did not receive their prescribed liquid potassium because the home did not have the medication available in the facility. The residence did not report this incident to the Department .

Plan of Correction ***Accept [redacted] 12/12/2024)***

The resident reported to the department on site he did not receive the potassium but did not report that to the home.
When the home was given the information that he reported, it was investigated and reported to the state.
All medication errors will be reported to the state within the regulation.
All med techs and nurses will be trained on reporting to the Director of Nursing or the Administrator any medication errors immediately so they can be investigated and reported.
Training was given by the DON on 11/8/24, 11/9/24, The Five Rights of Medications
The Director of Nursing or designee will complete a cart audit on each cart
weekly that will be turned in to the administrator to ensure that all medications are in the cart.
The audits will continue weekly for one year from 1/6/2025
A copy of the reportable will be attached to this response

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented [redacted] - 01/09/2025)

17 Record confidentiality

2. Requirements

2800.
17. Confidentiality of Records - 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

On [redacted], at approximately 10:30am, Resident [redacted] medication list was left on top of the second floor medication cart unattended and accessible in view to residents and visitors.

On [redacted], at approximately 11am, the narcotic control log was left on top of the first floor medication cart unlocked, unattended and accessible to residents and visitors.

Plan of Correction ***Accept [redacted] - 12/12/2024)***

The medication list and narcotic log were immediately locked inside the cart.
The medication technician was disciplined and trained
A HIPPA training will go out to all staff, 12/3/24
The Administrator, Director of Nursing, Community Liaison Manager or designee will do rounds daily to ensure all personal information is kept private
Weekly cart audit will be completed and HIPPA will be part of that audit.

17 Record confidentiality (continued)

The audit will be turned into the Administrator for one year beginning 1/6/25

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented [redacted] - 01/09/2025)

85a Sanitary conditions

3. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted], at approximately 9:50am, a strong odor was present upon entering Resident [redacted] bedroom. A substance appearing to be dried feces was observed around the toilet bowl and toilet seat in their bathroom.

Plan of Correction ***Accept ([redacted] - 12/12/2024)***

A work order was completed, and the toilet was cleaned immediately
Training will be done with all staff on reporting any soiled areas in the resident rooms or common areas
The training will be done by the DON, Administrator and RCC beginning 12/9/24
Rounds will be done by the Administrator, Director of Nursing, Community Liaison Manager or designee each week to ensure toilets are clean and free of debris. Rounds were done 11/8/24 and will be completed daily for one year from 1/6/2025

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented [redacted] - 01/09/2025)

141b1 Annual medical evaluation

4. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept [redacted] - 12/12/2024)***

The 2023 ADME was not completed, and we cannot go back and complete it
The ADME on file is current for this year
An audit was completed on all ADMEs 11/8/24, 11/9/24,11/10/24,11/11/24
A new tracking sheet was created and will be updated by the Director of Nursing or designee and turned into the Administrator monthly, by the last day of the month for the next month.
The tracking sheet was started on 12/3/24
The tracking sheets includes, apartment number, resident name, admission date, current ADME date, ADME annual due date and any needs that we have on that paperwork
The ADME tracking sheet will be in place indefinitely

Licensee's Proposed Overall Completion Date: *01/06/2025*

141b1 Annual medical evaluation *(continued)*

Implemented [redacted] - 01/09/2025)

162c Menus - posted

5. Requirements

2800.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted] the menus for the weeks of [redacted] to [redacted] were posted near the first floor dining hall. However, the weekly menu for the upcoming week was not displayed in a conspicuous place in the home.

Plan of Correction ***Accept ([redacted] - 12/12/2024)***

The menu for the following week was posted immediately
The regulation was reviewed with the dining management staff
The dining room manager completed this on 12/2/24
The dining room manager will confirm the appropriate menus are posted Monday of every week.
The Administrator will check weekly to ensure this is complete. for one year from 1/6/25

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented [redacted] - 01/09/2025)

183e Storing Medications

6. Requirements

2800.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] The following medication cards were observed to have a punctured blister foil with the medication still present in the spot which is an improper storage method and can result in medication error, lost medication and possible contamination.

- *Resident #3's Midodrine 10mg blister pack*

Plan of Correction ***Accept [redacted] - 12/12/2024)***

The medication was taken out of the cart with the inspector
A med cart assignment has been put into place to be done daily by the nurse or med tech at each shift and turned into the Resident Care Coordinator
Any medication found that had damaged packaging will be removed from the cart immediately and reported to the Director of Nursing
A weekly cart audit will be conducted by the Director of Nursing or designee beginning on 12/16/24
The audit will be turned into the Administrator to one year from the date 1/6/25

Licensee's Proposed Overall Completion Date: *01/06/2025*

183e Storing Medications *(continued)*

Implemented [redacted] - 01/09/2025)

184a Resident meds labeled

7. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The directions on Resident [redacted] pharmacy label for [redacted] tablet reads "take 1 tablet by mouth daily at bedtime", however the residents November 2024 Medication Administration record and current physician order reads take 1 tablet orally once daily" and is scheduled for 9am.

Plan of Correction ***Accept ([redacted] - 12/12/2024)***

The medication was immediately removed from the cart
Pharmacy delivered a new prescription for this medication with the correct administration instructions
The DON will complete a training on ensuring proper labeling beginning 12/9/24
A cart audit will be conducted weekly beginning 12/16/24 by the Director of Nursing or designee and will be turned into the Administrator indefinitely

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented ([redacted] 01/09/2025)

185a Storage procedures

8. Requirements

2800.
185.a. The residence 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 the following medications as needed. On 11/7/24, these medications were not available in the residence:

- *[redacted], 2 sprays in each nostril in the morning as needed.*
- *[redacted], apply topically three times a day as needed for itching.*
- *[redacted], take 1 capsule by mouth three times daily as needed.*
- *[redacted], dissolve 1 lozenge in mouth every 4 hours as needed for cough.*

Plan of Correction ***Accept [redacted] - 12/12/2024)***

The resident was self-medicating, when these medications were discontinued the resident did not inform the home.
We did not discontinue medications because we were unaware
We immediately got a D/C order for medications that were no longer in use
We received new orders for the medications the doctor wanted to continue with because they were not prescribed by them.
Daily assignment sheet is now in place on every cart for every shift to be complete by the nurse or med tech
DON trained the med techs/nurses on the med tech assignment sheet 12/1/24
Moving forward a cart audit will be done weekly by the Director of Nursing or designee
Both the audit and assignment sheet will be given to the administrator monthly

185a Storage procedures (continued)

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented (- 01/09/2025)

187b Date/time of med admin

9. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident is prescribed by mouth in the afternoon. Resident medication administration record was initialed by a staff person as administered on 11/4/24; however, the resident stated they did not receive it and the medication was not available in the residence.

Plan of Correction ***Accept (- 12/12/2024)***

The nurse who was responsible was an agency nurse and was DNR'd from the community
A training on the 5 rights of medication was given to the med techs and nurses by the DON the same day as the inspection. 11/7/24
Ongoing, a daily assignment sheet was created for the med carts, to be done by the med tech or nurse each shift to ensure that each cart is completed stocked and ready to go for the next shift
The daily assignment sheet will be given to the administrator monthly indefinitely

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented - 01/09/2025)

187d Follow prescriber's orders

10. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident is prescribed by mouth in the afternoon. However, this medication was not administered to resident on or because the medication was not available in the residence.

Resident was prescribed tab, take 1 tablet orally once a day for 7 days starting at 9:00am. However, on at 9:00am, this medication was not administered to the resident.

Resident is prescribed 1 drop in the affected eye once daily. However, this medication was not available in the residence.

Plan of Correction ***Accept (- 12/12/2024)***

The potassium was immediately administered the night of 11/5/24 and the provider was notified.
A reportable was completed and sent to the state two times.
A training on the 5 rights of medication was given to the med techs and nurses by the DON the same day as the inspection 11/7/24

187d Follow prescriber's orders (continued)

Ongoing, a daily assignment sheet was created for the med carts, to be done by the med tech or nurse each shift to ensure that each cart is completed stocked and ready to go for the next shift
A weekly cart audit will be conducted by the Director of Nursing or designee and given to the administrator monthly

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented (01/09/2025)

188b Medication error reporting

11. Requirements

2800.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident is prescribed by mouth in the afternoon. However, this medication was not administered to resident on or because the medication was not available in the residence. The medication error was not reported to the resident's designated person or the prescriber until .

Plan of Correction ***Accept (- 12/12/2024)***

The resident reported to the department on site he did not receive the potassium but did not report that to the home.
When the home was given the information that he reported, it was reported to the physican.
The resident is responsible for himself and was aware of the error
All medication errors will be reported to the resident, residents designated person and provider within 24 hours
All med techs and nurses will be trained on reporting to the Director of Nursing or the Administrator any medication errors immediately so they can be investigated and reported.
Training was done by the DON 11/7/24 on the Five Rights of Medication and what to do if you miss a medication.
The Director of Nursing or designee will complete a cart audit on each cart
weekly that will be turned in to the administrator to ensure that all medications are in the cart.

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented - 01/09/2025)

225a1 Assessment – annually

12. Requirements

2800.
225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident most recent assessment was completed on The resident did not have an annual assessment completed in 2023. The resident's previous assessment was completed on 9/28/22.

Plan of Correction ***Accept - 12/12/2024)***

The 2023 ASP was not completed, and we cannot go back and complete it
The ASP on file is current for this year
An audit was completed on all ASPs 11/7/24, 11/8/24, 11/9/24, 11/10/24, 11/11/24
A new tracking sheet was created and will be updated by the Director of Nursing or designee and turned into the

225a1 Assessment – annually (continued)

Administrator monthly, by the last day of the month for the next month indefinitely
The tracking sheet includes Apartment number, resident name, any change of status dates, current asp date, asp due date, the quarterly reviews for the year
The ASPs for the following month will be completed by the Director of Nursing, designee

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented [redacted] - 01/09/2025)

227c Final support plan - revision

13. Requirements

2800.
227.c. The final 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. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident [redacted] support plan has not been reviewed on a quarterly basis, the last review was completed on [redacted].

Plan of Correction ***Accept [redacted] - 12/12/2024)***

The support plan was reviewed immediately by the RN and signed
An audit was conducted on ASPs and the quarterly reviews, 11/7/24, 11/8/24, 11/9/24, 11/10/24, 11/11/24
An audit will be done monthly by the Director of Nursing or designee and turned into the Administrator indefinity
All quarterly reviews will be on time by the RN in the community

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented [redacted] 01/09/2025)

227d Support plan – med/dental

14. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Resident [redacted] requires a mechanical soft diet according to their medical evaluation dated [redacted]. However, the support plan dated [redacted], does not indicate this special dietary need.

Resident [redacted] doctor determined that the resident needs a bedside mobility device for turning and repositioning in bed. The resident's support plan, dated [redacted], does not indicate a need for this device or address how this need will be met.

Resident [redacted] doctor determined that the resident needs a bedside mobility device for turning and repositioning in bed. The resident's support plan, dated [redacted] does not indicate a need for this device or address how this need will be met.

227d Support plan – med/dental (continued)

Plan of Correction ***Accept [redacted] - 12/12/2024)***

The support plans were reviewed immediately by the RN and updated
An audit was conducted on ASPs, quarterly reviews and content 11/7/24, 11/8/24, 11/9/24, 11/10/24, 11/11/24
An audit will be done monthly by the Director of Nursing or designee and turned into the Administrator indefinitely
All quarterly reviews will be on time by the RN in the community
All significant changes will be added to the ASP by the Director of Nursing or designee and reviewed by the RN

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented [redacted] - 01/09/2025)