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

December 2, 2024

[redacted], SENIOR VICE PRESIDENT
ALLIED SERVICES PERSONAL CARE INC
[redacted]

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

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/06/2024 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ALLIED SERVICES MEADE STREET RESIDENCE* **License #**: *22812* **License Expiration**: *10/02/2025*

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

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

Administrator

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

Legal Entity

Name: *ALLIED SERVICES PERSONAL CARE INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/29/1998* **Issued By**: *l&i*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *11/06/2024*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *76* **Residents Served**: *56*

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**: *56*

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

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

Inspections / Reviews

11/06/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/23/2024*

11/22/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/27/2024*

Inspections / Reviews *(continued)*

11/26/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/27/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/01/2024*

12/02/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/27/2024*

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

18 Compliance With Laws

1. 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 carbon monoxide monitors installed to monitor the home's lobby area fireplace and the Terrace level gas fired boiler system were not labeled with the dates they were installed. Both carbon monoxide monitors have internal batteries with a 10 year life expectancy and should have been labeled with dates indicating when to replace the monitors.

Plan of Correction ***Accept (- 11/26/2024)***

1. The carbon monoxide monitors located in the lobby and the Terrace level gas fired boiler installed on 5/16/24, were labeled on 11/6/24.
2. Facility staff were verbally re-educated by Administrator on safety requirements on 11/6/24.
3. Facility staff will perform on going weekly checks on the carbon monoxide monitors located in the lobby and the Terrace level gas fired boiler. A facility work order for "Replace by date" as well as an annual work order to ensure any batteries accessible are dated and changed yearly. Documentation of above will be kept on file by facility staff.
4. Administrator will monitor compliance.

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented - 12/02/2024)

65g Annual Training Content

2. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in the required training topics Older Adult Protective Services Act and resident rights for the 10/1/23 to 9/30/24 training year. Staff person A's date of hire is .

Plan of Correction ***Accept (- 11/26/2024)***

1. On 11/15/24, Staff member A was in-serviced by Administrator in OAPSA and Resident Rights to ensure compliance.
2. An audit will be completed by Administrator on 11/26/24 to ensure all annual trainings of all staff are up to date as required.
3. Administrator will review Annual trainings as part of the quarterly QA.

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented (- 12/02/2024)

65g - Annual Training Content *(continued)*

82c - Locking Poisonous Materials

3. 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

During the initial walk through the shower room located in the secure dementia unit near the laundry room was unlocked and the door was propped open. On a shelf in the shower room the following items were found: several bottles of anti-fungal powder and bottles of antiperspirant. Both items had labels indicating to seek medical attention if swallowed.

Plan of Correction ***Accept ([redacted] - 11/22/2024)***

1. Shower room in the SDCU will be locked when not in use.
2. To ensure compliance all staff that work in the homes SDCU will be re-educated by the Administrator on this regulation by 11/27/24.
3. Assistant Administrator will perform bi-weekly inspections in the homes SDCU to ensure the shower room door is locked when not in use.
4. Administrator will perform bi-weekly audit in SDCU to ensure compliance and report results as part of the quarterly QA.

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented [redacted] - 12/02/2024)

103f - Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

During the initial walk through the refrigerator in the 2nd floor kitchenette area did not have a thermometer in it to monitor the temperature of the refrigerator.

Plan of Correction ***Accept [redacted] - 11/22/2024)***

1. During the inspection, dietary staff noticed the thermometer in the 2nd floor kitchenette fridge was cracked. Thermometer was removed by the dietary staff to prevent any resident harm and the dietary director was made aware immediately. A new thermometer was placed in the 2nd floor kitchenette fridge by the dietary director during the inspection.
2. Dietary staff will inspect 2nd floor kitchenette fridge daily to ensure thermometer is visible and in good repair.
3. Administrator will review dietary fridge audits as part of the quarterly QA.

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented ([redacted] - 12/02/2024)

121a - Unobstructed Egress

5. Requirements

121a - Unobstructed Egress *(continued)*

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 home's front door used by residents and visitors to exit to the parking lot area requires the use of a keypad to unlock the door to exit. The door also has a delayed egress system that unlocks the door after 15 seconds when pushed. The door is not in the licensed secure dementia area of the home. Upon arrival to the home there was a sign on the door indicating "Please see staff for code to exit building. Alarm will sound." The home did not have a sign to also indicate to push the door to open after 15 seconds.
Also, the exit door located in the Lehigh wing stairwell was equipped with a keypad used to unlock the door to allow egress. The Lehigh wing is not part of the home's licensed secure dementia unit. The door has a panic bar which will unlock the door after it is pressed for 30 seconds. The door did not include any signage indicating to exit using the code on the keypad and did not have any signage indicating to press the panic bar for 30 seconds to exit.

Plan of Correction ***Accept ([redacted] - 11/26/2024)***

1. During the time of inspection, a sign reading "PUSH DOOR UNTIL ALARM SOUNDS DOOR WILL OPEN IN 15 SECONDS" was placed on the homes from door and on the exit door of Lehigh wing.
2. Facility staff were verbally re-educated by Administrator on requirement on 11/6/24
3. Ongoing weekly checks will be performed by maintenance on all egress doors containing the delayed egress. Any malfunction of the system will be addressed immediately with the appropriate vendors.
4. Documentation of the weekly egress door checks will be kept on file by facility staff. Administrator will monitor compliance.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented ([redacted] - 12/02/2024)

184a - Resident's Meds Labeled

6. 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 #1 has an order for [redacted] sprays in both nostrils one time daily. The pharmacy label for the medication indicates the order is for 2 sprays in both nostrils daily for 14 days.
Resident #2 has an order for [redacted], one tablet as needed at bedtime. The pharmacy label for the medication indicates the order is for one tablet nightly. The pharmacy label does not indicate that the order is as needed.

Plan of Correction ***Accept [redacted] - 11/26/2024)***

1. During the time of inspection, a "directions change sticker" was placed on Resident #1 [redacted] box and on Resident #2 [redacted] bottle.
2. Pharmacy was notified by administrator to ensure label matches the order in the EMAR going forward.
Appropriate home staff will be re-educated by Administrator by 11/27/24 to ensure physician order matches label on medication

184a Resident's Meds Labeled (continued)

3. Medication audits will be performed by assistant administrator monthly to ensure accuracy and compliance.

4. Monthly medication audits will be reviewed by Administrator as part of the quarterly QA.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented (- 12/02/2024)

185a - Implement Storage Procedures

7. 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 #3's glucometer was not calibrated to the correct date.

Plan of Correction ***Accept (- 11/26/2024)***

1. Resident #3 was provided a new glucometer day of inspection.

2. All glucometers will be audited by assistant administrator on 11/26/24 and then weekly to ensure all dates and times are accurate and to ensure compliance.

3. Administrator will review weekly glucometer audits as part of the quarterly QA.

Licensee's Proposed Overall Completion Date: *11/27/2024*

Implemented - 12/02/2024)