**Department of Human Services**
**Bureau of Human Service Licensing**

March 29, 2022

[REDACTED], ADMINISTRATOR
LIFEQUEST NURSING CENTER
2460 JOHN FRIES HIGHWAY
QUAKERTOWN, PA, 18951

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

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/03/2022, 03/04/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

### Facility Information

**Name**: *THE VILLAGE AT LIFEQUEST* **License #**: *14496* **License Expiration**: *11/07/2022*

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

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

### Administrator

**Name**: [redacted] **Phone**: *267-424-2096* **Email**: [redacted]

### Legal Entity

**Name**: *LIFEQUEST NURSING CENTER*

**Address**: *2460 JOHN FRIES HIGHWAY, QUAKERTOWN, PA, 18951*

**Phone**: *2674242096* **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**: *97* **Waking Staff**: *73*

### Inspection Information

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

**Reason**: *Renewal* **Exit Conference Date**: *03/04/2022*

### Inspection Dates and Department Representative

*03/03/2022 - On-Site:* [redacted]
*03/04/2022 - On-Site:* [redacted]

### Resident Demographic Data as of Inspection Dates

#### General Information

**License Capacity**: *141* **Residents Served**: *75*

#### 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**: *73*

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

**Have Mobility Need**: *22* **Have Physical Disability**: *1*

## Inspections / Reviews

### 03/03/2022 - Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2022*

## Inspections / Reviews *(continued)*

**03/22/2022 - POC Submission**

**Reviewer:** [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/01/2022*

**03/29/2022 - Document Submission**

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

## 22a1 Medical Eval - time frames

**1. Requirements**

2800.
22.a. Documentation. The following admission documents shall be completed for each resident:
1. Medical evaluation completed within 60 days prior to admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies

**Description of Violation**

*Resident # 1 was admitted on [redacted]. The resident's medical evaluation was not completed.*

**Plan of Correction** ***Accept***

*1. The medical evaluation was signed and dated by the doctor but the date was not put on the front of the form.*

*2. The date was confirmed by the doctor and added to the form per plan of correction*

*3. An audit will be done of all ADMEs and given to the administrator*

*4. A tickler system will be put into place by the Compliance and Quality Manager to be reviewed monthly*

*5. A report will be given to the administrator for follow up*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*This is our audit form for ADMEs*

## 63a First Aid/CPR 1:35

**1. Requirements**

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

**Description of Violation**

*On 2/6/22, from 11:00pm to 7:00am, 73 residents were present in the residence. During this time only 2 staff persons were present in the residence who were trained in first aid and certified in obstructed airway techniques and CPR.*

*On 2/19/22, from 11:00pm to 7:00am, 73 residents were present in the residence. During this time only 2 staff persons were present in the residence who were trained in first aid and certified in obstructed airway techniques and CPR.*

**Plan of Correction** ***Accept***

*1. The CPR certificate for the agency staff were not in the file.*

*2. We immediately did an audit of our contractor binder, contacted agency and got the current certification.*

*3. We have a list of employees who need or will soon expire that we are scheduling a CPR class for*

*4. An asterisk has been added on the schedule to the staff who have their current CPR to ensure that we have the correct amount scheduled.*

*5. The schedule is reviewed daily by the administrator or designee*

*6. The schedule will continue to be reviewed daily and daily sheets posted*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*The asterisk is being added to the name of the person who is CPR certified on the shift*

*A class is also being scheduled*

*All staff is required to be certified*

## 65a Fire Safety-1st day

**1. Requirements**

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

**Description of Violation**

*Staff person A, whose first day of work was [redacted], and Staff person B, whose first day is undocumented at the home, did not receive orientation on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, The designated meeting place outside the building or within the fire-safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, The location and use of fire extinguishers, Smoke detectors and fire alarms, Telephone use and notification of emergency services .*

**Plan of Correction** ***Accept***

*1. Two agency staff who were oriented did not sign the correct paperwork for their orientation*
*2. All agency staff have been required to complete a fire safety review and the correct paperwork*
*3. All paperwork for new agency staff will be reviewed by the Compliance and Quality Manager whenever a new agency person starts to ensure we have all the required documentation*
*4. Any agency that does not provide the correct documentation will not be scheduled to work at the Village*
*5. A checklist for the agency paperwork has been created and attached to their information when they*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*The agency staff did sign the correct paperwork and it is being used on going*
*An agency training binder has been implemented as well*

## 65e Rights/Abuse 40 Hours

**1. Requirements**

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
    i. Person-centered care.
    ii. Communication, problem solving and relationship skills.

## 65e Rights/Abuse 40 Hours *(continued)*

iii. Nutritional support according to resident preference.

**Description of Violation**

*Staff person A, whose first day of work was [redacted], has worked at the home on multiple dates since their first day, amounting to more than 40hrs. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions, safe management techniques, core competency training that includes the following: person-centered care , core competency training that includes the following: communication, problem solving and relationship skills , core competency training that includes the following: nutritional support according to resident preference .*

*Staff person B, whose first day of work is undocumented by the home, has worked at least 40 hours as of [redacted]. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions, safe management techniques, core competency training that includes the following: person-centered care , core competency training that includes the following: communication, problem solving and relationship skills , core competency training that includes the following: nutritional support according to resident preference .*

**Plan of Correction** ***Accept***

*1. Two agency staff who were oriented did not sign the correct paperwork for their orientation*

*2. All agency staff have been required to complete a review and the correct paperwork*

*3. All paperwork for new agency staff will be reviewed by the Compliance and Quality Manager whenever a new agency person starts to ensure we have all the required documentation*

*4. Any agency staff that does not complete the required training will not be permitted to stay and work at the Village*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*The agency staff did sign the correct paperwork and it is being used on going*

*An agency training binder has been implemented as well*

## 69 Dementia training

**1. Requirements**

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

**Description of Violation**

*Staff person A, date of hire [redacted], has not received any hours of dementia-specific training within 30 days of hire.*

**Plan of Correction** ***Accept***

*1. One of our agency staff who were trained did not sign the correct paperwork for their orientation*

*2. All agency staff have been required to complete a review and the correct paperwork*

*3. All paperwork for new agency staff will be reviewed by the Compliance and Quality Manager whenever a new*

## 69 Dementia training (continued)

*agency person starts to ensure we have all the required documentation*

*4. Any agency staff that does not complete the required training will not be permitted to stay and work at the Village*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*The agency staff did sign the correct paperwork and it is being used on going*

*An agency training binder has been implemented as well*

## 105g Dryer lint removal

**1. Requirements**

2800.
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**

*On 3/4/22, there was an approximate 1/4 inch accumulation of lint in the lint trap of the AL1- first floor laundry- 1st dryer. There were no clothes in the dryer at the time.*

**Plan of Correction** ***Accept***

*1. Lint was left in a first floor dryer*

*2. The lint was taken out right as we found it*

*3. Signage was replaced in a more colorful way about removing lint after each use*

*4. Residents who are doing their own laundry will get a copy of the sign as a reminder*

*5. It will be added to the assignment sheet for each aide to check the dryers at the beginning and end of their shift.*

*6. Random checks will be performed by the administrator and designee*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*Cleaning of the lint is a daily task on the assignment sheets and is being monitored by the administrator/designee*

## 132h Designated meeting place

**1. Requirements**

2800.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

**Description of Violation**

*During the fire drill on 12/10/21, at 10:00pm, 58 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.*

*During the fire drill on 1/27/22, at 4:30am, 72 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.*

*During the fire drill on 2/15/22, at 8:00pm, 72 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.*

*As reported by residents and staff, residents are remaining in their rooms, until told to evacuate by staff or until the drill*

## 132h Designated meeting place (continued)

*has concluded, however, residents are not accounted for in a designated meeting place if their room is considered to be in the fire safe area.*

**Plan of Correction** ***Accept***

*1. The fire drill log that was used for the drill did not have the column completed which showed how many residents participated in the fire drill.*
*2. The log has been updated to include the number of residents that are participating in the fire drill*
*3. A staff fire safety training was completed before the inspections*
*4. A fire safety training is scheduled for the next resident council meeting*
*5. The maintenance director and administrator will monitor the fire drills to ensure a proper count is being conducted and signed off on and verified*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*We added how many residents participated in the fire drill to our log*

## 141a Medical evaluation

**1. Requirements**

2800.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

**Description of Violation**

*The medical evaluation for resident # 2, dated [redacted], does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.*

*The medical evaluation for resident #3, dated [redacted], does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.*

*The medical evaluation for resident #4, dated [redacted], does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.*

*The medical evaluation for resident #5, dated [redacted], does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.*

*The medical evaluation for resident #6, dated [redacted], does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.*

**Plan of Correction** ***Accept***

*1. The medication lists were not attached to the ADMEs in the resident record.*
*2. The medication lists are reviewed every six months instead of annually so were kept in a separate area of the resident record*
*3. The medication lists were attached to the resident records*

## 141a Medical evaluation (continued)

*4. The Resident Care Director will attach the medication administration record to the ADME when the annual review is taking place.*

*5. The Compliance and Quality Manager will audit the ADMEs monthly and give the report the Administrator and/or designee*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*An ADME audit sheet has been created and will be complete by May 1*

## 141b1 Annual medical evaluation

**1. Requirements**

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

**Description of Violation**

*Resident #2's most recent medical evaluation was completed on [redacted].*

**Plan of Correction** ***Accept***

*1. The medical evaluation was done for [redacted]*

*2. A tickler file is being created by our RN*

*3. The tickler file will be reviewed at the end of every month to see who is due for their annual ADME*

*4. The ADME form will be put into the doctors book for completion with the med list attached.*

*5. A monthly audit will be done by our Compliance and Quality Manager and given to the Administrator*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*Our RN has reviewed all our ASPs and signed off on them.*

## 171b5 Transportation-first aid kit

**1. Requirements**

2800.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

**Description of Violation**

*The first aid kit in the bus used to transport residents does not include eye coverings.*

**Plan of Correction** ***Accept***

*1. The first aide kit on the bus did not have protective eye coverings*

*2. The protective eye coverings were added to the first aide kit that day*

*3. A copy of the regulation is attached to the first aid kit*

*4. The transportation manager will perform monthly audits for the next 12 months*

*5. Audits will be reviewed by the administrator*

*6. All audits will be reported in our quality assurance process, to track, monitor and identify any trends*

**Completion Date:** *05/01/2022*

## 171b5 Transportation-first aid kit *(continued)*

**Document Submission** ***Implemented***

*A audit has been created for the van first aide kit and will be done monthly*

## 183d Current medications

**1. Requirements**

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

**Description of Violation**

*On 3/4/22, a bottle of [redacted] prescribed for resident # 7, was in the residence's medication cart 3; however, the medication was discontinued on 1/21/22.*

**Plan of Correction** ***Accept***

*1. The aspirin was removed immediately from the cart*

*2. Ongoing the medication carts will audited weekly*

*3. All audits will be reviewed by the Resident Care Director*

*4. Audit will be given to the administrator*

*5. Audits will be brought to the Quality Assurance meetings to be tracked and monitored for trends*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*a new chart audit form has been created to be done weekly*

## 183e Storing Medications

**1. 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 3/4/22, a blister package of [redacted], belonging to resident #7, was stored in the narcotics drawer of medication cart 3.  There was tape on the back of the blister packaging used to hold in a pill in the #40 blister.*

**Plan of Correction** ***Accept***

*1. The medication was destroyed appropriately*

*2. All nursing staff has been educated that they are not allowed to remove a medication and tape the back of the blister packaging. All medication must remain properly intact until properly dispensed, if opened or tampered with the administrator is notified immediately and the medication will be destroyed*

*3. As part of the audit, all medications will be looked at for packaging*

*4. All audits will be reviewed by the Resident Care Director*

*4. Audit will be given to the administrator*

*5. Audits will be brought to the Quality Assurance meetings to be tracked and monitored for trends*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*a new chart audit form has been created to be done weekly*

## 184a Labeling

**1. Requirements**

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

**Description of Violation**

*The pharmacy label for resident # 9's [redacted] is completely missing, having been torn off the bottle.*

**Plan of Correction** ***Accept***

*1. The medication was labeled immediately*

*2. The staff was educated on correctly labeling the of any medication in the carts*

*3. Medication carts will be audited weekly, proper labeling is part of the audit*

*4. Audits will be given to the Administrator*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*a new chart audit form has been created to be done weekly*

## 184b Resident meds labeled

**1. Requirements**

2800.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

**Description of Violation**

*On 3/4/22, three bottles of OTC medication belonging to resident # 10 was in the medication cart 3 and was not labeled with the resident's name.*

**Plan of Correction** ***Accept***

*1. The medication was labeled immediately*

*2. The staff was educated on correctly labeling the of any medication in the carts*

*3. Medication carts will be audited weekly, proper labeling is part of the audit*

*4. Audits will be given to the Administrator*

*5. Audits will be reported through our Quality Assurance meetings*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*a new chart audit form has been created to be done weekly*

## 185a Storage procedures

**1. 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.

## 185a Storage procedures *(continued)*

**Description of Violation**

*Resident #1 is prescribed [redacted], take one by mouth every 6 hours as needed (for diarrhea), this medication is not present in the home on 3/4/22.*

*The glucometer belonging to resident #7 is not calibrated to correct time. On 3/4/22 at 12:02pm, the glucometer time is 11:08am.*

**Plan of Correction** ***Accept***

*1. The glucometer was calibrated immediately*

*2. Glucometer audits will be part of the medication cart audits.*

*3. Audits are completed by the Resident Service Director and/or designee*

*3. Community will specifically do an audit on Daylight savings time twice a year*

*4. Audits will be given the Administrator*

*5. Audits will be reviewed at the Quality Assurance meetings.*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*a new chart audit form has been created to be done weekly*

## 225a1 Assessment – annually

**1. 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 # 2's most recent  assessment was completed on [redacted]*

**Plan of Correction** ***Accept***

*1. The assessment form was done immediately completed*

*2. A tickler file was created by the RN*

*3. An audit will be completed by the Compliance and Quality Manager*

*4. A copy of the audit will be given to the administrator*

*5. The audit will be reported at our Quality Assurance meeting for tracking and trending.*

**Completion Date:** *05/01/2022*

**Document Submission** ***Implemented***

*Our RN created her own tickler file to track the ASPs*