Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

April 12, 2023

QUINCY RETIREMENT COMMUNITY

RE: PARKER HOUSE ASSISTED LIVING
6596 ORPHANAGE ROAD
WAYNESBORO, PA, 17268
LICENSE/COC#: 33317

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/13/2022, 09/14/2022 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PARKER HOUSE ASSISTED LIVING* **License #**: *33317* **License Expiration**: *04/24/2023*

Address: *6596 ORPHANAGE ROAD, WAYNESBORO, PA 17268*

County: *FRANKLIN* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *QUINCY RETIREMENT COMMUNITY*

Address: *6596 ORPHANAGE ROAD, QUINCY VILLAGE, HOPE LAMBERT ED, WAYNESBORO, PA, 17268*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/01/2015* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *09/15/2022*

Inspection Dates and Department Representative

09/13/2022 - On-Site:
09/14/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *40*

Special Care Unit

In Home: *Yes* **Area**: *Building 2* **Capacity**: *16* **Residents Served**: *15*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*

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

Have Mobility Need: *16* **Have Physical Disability**: *0*

Inspections / Reviews

09/13/2022 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/01/2022*

10/12/2022 - POC Submission

Submitted By: **Date Submitted**: *12/06/2022*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/19/2022*

Inspections / Reviews *(continued)*

11/16/2022 - POC Submission

Submitted By: [redacted]
Date Submitted: *12/06/2022*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *11/23/2022*

04/12/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *12/06/2022*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 9/13/2022, the residence's most recent license inspection summary, issued by The Department, dated 1/31/2020, was not posted in a conspicuous and public place in building 1 of the residence.

POC Submission ***Accept (KB - 10/07/2022)***

A copy of the 1/31/2020 inspection summary was placed into the posting book on 9/13/2022. Administrator and designee were educated on 9/21/2022. An audit will be completed monthly by administrator or designee to ensure the summary is posted. Audit will be reviewed for three months in Quality Management meeting.

Licensee's Plan Completion Date: *09/30/2022*

Implemented (KB - 12/09/2022)

23a ADL assistance

2. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident's #3's most recent support plan dated [redacted] indicates that Resident #3 requires "extensive supervision", and is violent, verbally or physically. According to the internal "Behavior Monitor Log", between 7/6/22 and 9/14/22, there have been at least 75 separate instances of agitation, aggravation, or inappropriate behavior. Resident #3 did not receive appropriate supervision as required by his/her assessment and support plan as evidenced by the incidents that occurred between 7/6/22 and 9/14/22.

POC Submission ***Directed (KB - 11/15/2022)***

Resident #3 has been evaluated by physician on [redacted] and will be evaluated by behavioral health on [redacted] for additional recommended actions and any necessary update for level of support required. Family will be made aware of recommendations, and other arrangements for care may need considered.

(Directed)
- By 12/1/22, the Administrator will review both the medical and behavioral health evaluations and make adjustments including but not limited to requiring additional support for the appropriate supervision of Resident # 3.
- The administrator will re-train all care staff on the importance of ADL assistance specific to behavioral needs by 12/15/22.
- Beginning 12/1/22, the administrator will review the "Behavior Monitor Log" on a weekly basis to determine and evaluate the continuing behavioral needs of the residents.
- The administrator will document the results of this weekly review and discuss findings with management staff during the next quality management meeting to be held no later than 12/31/22.

Directed Completion Date: *12/01/2022*

Implemented (AS - 04/12/2023)

25b Contract signatures and renewal

3. Requirements

2800.
25b . The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident # 2 was admitted to the home on [redacted]. The resident did not sign the contract, nor was any documentation present indicating that he/she was unable to sign the contract.

POC Submission ***Accept (KB - 10/07/2022)***

Contract for Resident #2 was completed with their signature on [redacted]. current resident contracts have been audited on 9/15/2022 to ensure completion. Education provided to administrator and designee, on 9/21/2022, to ensure signature is obtained upon admission. New admission contracts will be reviewed monthly by the administrator or designee for signatures. Audit will be reviewed for three months in Quality Management meeting.

Licensee's Plan Completion Date: *09/30/2022*

Implemented (KB - 12/09/2022)

42b Abuse/Neglect

4. Requirements

2800.
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

Residents #2, 3 and 4 all reside in building two, the secured care unit of the residence.

On 7/21/22, Resident #3 was observed by staff with his/her hand down Resident #4's shirt.

On 8/2/22 at approximately 7:45pm, Resident #3 was holding hands with Resident #4. After re-direction, at approximately 7:50pm, Resident #3 went to Resident #5 and attempted to bring [redacted] closer, and was again re-directed by staff. By approximately 8:15pm, Resident #3 was found in the vanity area of Resident #4's bedroom. Resident #4 had his/her pants down to their ankles, while Resident #3 was kissing [redacted]. Resident #3 became aggressive upon attempting to redirect and remove Resident #3 from the situation.

On 8/18/22 at approximately 10:30am, Resident #3 became agitated after staff tried to stop him/her from kissing Resident #4.

On 9/12/22 approximately 8:10am, Resident #3 kissed Resident #4 and tried to punch staff while they were trying to redirect Resident #3.

POC Submission ***Directed (KB - 11/15/2022)***

Resident #3 physician made aware of behaviors; behavioral health appointment scheduled for [redacted] for additional recommendations to support level of care. Resident will have supervision during scheduled group activities, with redirection provided immediately if inappropriate behavior is noted. If resident #3 is unable to be redirected, a safe distance will be provided to any other residents in that immediate area. Family will be made

42b Abuse/Neglect (continued)

aware of recommendations, and other arrangements for care may need considered. Private companion care is being provided to Resident #3 several times a week. Frequent monitoring will be conducted by caregiving staff to identify inappropriate behaviors and provide re-direction.

(Directed)
- Administrator will meet to discuss the medical and behavioral needs of Resident #3 with family and providers by [redacted] to determine the most appropriate care that the home can provide to to best meet the needs of Resident #3.
- Administrator will re-train all care staff on the importance of ADL assistance specific to behavioral needs by 12/15/22.
- Beginning 12/1/22, the administrator will review the "Behavior Monitor Log" on a weekly basis to determine and evaluate the continuing behavioral needs of the residents.
- The administrator will document the results of this weekly review and discuss findings with management staff during the next quality management meeting to be held no later than 12/31/22.

Directed Completion Date: *12/01/2022*

Implemented (AS - 04/12/2023)

65g Initial direct care training

5. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A has been providing unsupervised assisted living services since his/her hire date on [redacted]. Direct care staff person A does not have evidence of the successful completion and passing the Department-approved direct care training course and passing of the competency test as required.

POC Submission ***Accept (KB - 10/07/2022)***

Staff person A completed the required DCS certification on [redacted]. A copy of staff person A's DCS certification was placed in training book on 9/19/2022. Education provided to administrator and designee, on 9/21/2022, to have record of completion in training log. As new staff complete their certification, a copy will be immediately placed in the staff training book by administrator or designee. Staff training book will be audited monthly by administrator or designee to ensure DCS certification is documented. Audit will be reviewed for three months in Quality Management meeting.

Licensee's Plan Completion Date: *09/30/2022*

Implemented (KB - 01/05/2023)

102i Soap dispenser

6. Requirements

2800.

102i Soap dispenser *(continued)*

102.i. Bar soap or a dispenser with soap shall be provided within reach of each bathroom sink. Bar soap, however, is not permitted when a living unit is shared unless there is a separate bar clearly labeled for each resident sharing the living unit.

Description of Violation

There was an unlabeled, used bar of Dove soap and a bar of Irish Spring on top of the spa in the shared "Spa room" in building #1 belonging to unknown residents.

POC Submission ***Accept (KB - 10/07/2022)***

Unlabeled items were removed immediately on 9/13/2022. Staff education on state regulation 2800.102 i, was completed on 9/21/2022. Weekly audits will be completed by 3rd shift staff member to ensure there are no unlabeled bars of soap in spa. Audit will be reviewed for three months in Quality Management meeting.

Licensee's Plan Completion Date: *09/30/2022*

Implemented (KB - 01/05/2023)

103e Leftovers

7. Requirements

2800.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated bag of four (4) previously peeled hard boiled eggs in the fridge portion of the upright refrigerator/freezer in building 1.

There were also the following unlabeled and undated food products in the freezer in building one: Two freezer bags containing French toast, a previously opened bag of French fries and a previously opened bag of four burger patties.

POC Submission ***Directed (KB - 11/15/2022)***

Unlabeled items were removed from freezer and refrigerator. The scented spray H115 and the 2 bottles of renew repair cream in H134 were also removed and placed in a secured location on 9/27/2022. Staff re-educated about dating and labeling food products on 9/21/2022. Weekly audits will be completed by administrator or designee to ensure food products are
labeled. Audit will be reviewed for three months in Quality Management meeting.

(Directed)
-The Unlabeled items were removed from freezer and refrigerator by the Administrator on 9/13/22.
- By 12/1/22, the Administrator will inspect all refrigerators and freezers in all three buildings and remove and dispose of any and all unlabeled and undated food products found.
- The Administrator will train all staff by 12/15/22 on the regulation regarding food safety and its importance, and that they must notify management immediately when such issues are found.
- Starting 12/1/22, Administrator will conduct weekly walk-through audits to ensure that all food products are appropriately labeled.

Directed Completion Date: *12/01/2022*

103e Leftovers *(continued)*

Implemented (AS - 04/12/2023)

123b Emerg. procedures posted

8. Requirements

2800.
123.b. Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

Description of Violation

On 9/13/2022, the residence's emergency procedures were not posted in a conspicuous and public place in the residence.

POC Submission ***Accept (KB - 10/07/2022)***

A copy of the emergency procedures was placed with other posting book on 9/13/2022. Administrator and designee educated on 9/21/2022 to ensure the emergency procedures book is in a conspicuous and public place. Administrator or designee will audit placement of emergency procedure book monthly. Audit will be reviewed for three months in Quality Management meeting.

Licensee's Plan Completion Date: *09/30/2022*

Implemented (KB - 12/09/2022)

227g Support plan - signatures

9. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1 was admitted to the residence on [redacted] and participated in the development of his/her support plan. However, the resident did not sign or date the support plan.

POC Submission ***Directed (KB - 11/15/2022)***

Resident #1 signed their support plan on [redacted]. An audit of current resident support plans was completed on 9/15/2022 to ensure signatures. Administrator, designee and LPN were educated on 9/21/2022 to ensure support plans are signed. Administrator or designee will review support plans for completion monthly. Audit will be reviewed for three months in Quality Management meeting.

(Directed)
- The Administrator had Resident #1 sign the support plan on [redacted].
- The Administrator will audit all resident support plans by 12/15/22 to ensure appropriate signatures.
- The Administrator will develop and implement a support plan checklist by 12/1/22 to ensure that all support plans contain the required information and appropriate signatures.

Directed Completion Date: *12/15/2022*

Implemented (AS - 04/12/2023)

231c1 Preadmit screening

10. Requirements

2800.
231.c.1.i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident # 3 was admitted to the special care unit on [redacted].
The preadmission screening completed for Resident #3 on [redacted] does not include a determination that the resident's needs can be met by the home, this section was incomplete.

POC Submission ***Directed (KB - 11/15/2022)***

Resident 3#s preadmission screening determination section for [redacted] was completed on [redacted] An audit was completed on [redacted] of current residents preadmission screenings for completion. Administrator, designee and LPN were educated on 9/21/2022 to ensure prescreening completion. Administrator or designee will review preadmission screening for new admissions monthly for completion. Audit will be reviewed for three months in Quality Management meeting.

(Directed)
- The Administrator will document the reason for the non-compliant preadmission screening in Resident #3's record by 12/1/22.
- The Administrator will re-train the LPN by 12/15/22 on the timelines specific to residents of a secured care unit.
- The Administrator/LPN will audit all resident preadmission screenings by 12/15/22 to ensure that they are complete, accurate and within the required time parameters.
- The Administrator will develop and implement a new admission checklist by 12/15/22 to ensure that preadmission screenings are completed within the required timeframe,
- Administrator will review results of audit at the next quality management meeting to be held no later than 12/31/22.

Directed Completion Date: *12/31/2022*

Implemented (AS - 04/12/2023)

231d No objection statement

11. Requirements

2800.
231.d. Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

Description of Violation

Resident # 2 was admitted to the special care unit on [redacted]. However, the resident's record does not include documentation that the resident and the resident's designated person or the resident's family have agreed to the resident's admission to the special care unit.

POC Submission ***Accept (KB - 10/07/2022)***

Resident #2's consent for admission to a secure unit from [redacted], was completed on [redacted]. Audit was completed of current residents in the special care unit on [redacted] to ensure documentation of consent for admission to a secure unit have been completed. Administrator and designee were educated on 9/21/2022. Administrator or designee will audit new admissions to special care unit for consent of admission to a secure unit monthly. Audit will be reviewed for three months in Quality Management meeting.

231d No objection statement *(continued)*

Licensee's Plan Completion Date: *09/30/2022*

Implemented (KB - 01/05/2023)

233d Electronic/magnetic system

12. Requirements

2800.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

Building #2 is a Secured Dementia Care Unit. There are four exterior side doors which open to sidewalks around the building, and other parts of the campus. These four exterior doors are not locked with an electronic or magnetic locking system, unless the resident wears a "[redacted]" bracelet. However, even with a [redacted], the doors will release after 30 seconds of pressure on the panic bar, with no audible alarm system in place.

POC Submission ***Directed (KB - 11/15/2022)***

Building #2's doors were tested for audible alarm on 9/19/2022. A three stage alarm was noted as functioning for all 4 doors, including an alarm at staff pagers. The current monthly audit of the doors will be increased to weekly and will be performed by the maintenance team. Audit will be reviewed for three months in Quality Management meeting.

(Directed)
- Administrator tested the doors of building #2 on 9/19/22 for audible alarm.
- Administrator and Maintenance Director will re-train all employees of the importance of these alarms and the possibility of resident elopement by 12/15/22.
- Starting 12/1/22, Administrator and Maintenance Director will perform weekly walk-throughs of building two (2) to verify that the alarms continue to be in working order at all times.

Directed Completion Date: *12/15/2022*

Implemented (KB - 01/05/2023)

236a Staff training

13. Requirements

2800.
236.a. Each direct care staff person working in a special care unit for residents with Alzheimer’s disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person A, date of hire [redacted] works in the special care unit, but only completed 5.25 hours of initial training related to dementia care within the first 30 days of the date of hire.

POC Submission ***Directed (KB - 11/15/2022)***

Direct care staff person A has completed 8 hours of training related to dementia. Education was provided to administrator and designee on 9/21/2022 that within 30 days of hire 8 hours of dementia training must be

236a Staff training (continued)

completed. HR was educated on 9/21/2022, to ensure the 8 hours of dementia training are assigned to new staff upon hire and completed with in the first 5 days. Administrator or designee will audit training long monthly to verify education hours are completed. Audit will be reviewed for 3 months in Quality Management meeting.

(Directed)
- Administrator will verify that Staff Person A has completed the required hours of training related to dementia by 12/31/22.
- By 12/15/22, Administrator will re-train all staff regarding the dementia training requirement before working in building two (2).
- The administrator will develop and implement a new hire checklist by 12/15/22 that includes these additional educational qualifications.
- Beginning 12/15/22, the administrator will audit all staff records quarterly as part of the quality management plan.

Directed Completion Date: *12/15/2022*

Implemented (AS - 04/12/2023)