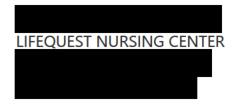
Department of Human Services Bureau of Human Service Licensing LICENSING INSPECTION SUMMARY - PUBLIC

April 26, 2023



RE: THE VILLAGE AT LIFEQUEST

2100 CHERRY BLOSSOM LANE QUAKERTOWN, PA, 18951 LICENSE/COC#: 14496

Dear Ms. Dee Jones.

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/17/2022 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

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Facility Information

Name: THE VILLAGE AT LIFEQUEST Licen e #: 14496 Licen e Expiration: 11/07/2023

Address: 2100 CHERRY BLOSSOM LANE, QUAKERTOWN, PA 18951

County: BUCKS Region: SOUTHEAST

Administrator

Name: Phone Email:

Legal Entity

Name: LIFEQUEST NURSING CENTER

Address:

Phone: Email:

Certificate(s) of Occupancy

Type: Other Date: 10/22/2019 I ued By: Milford Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 95 Waking Staff: 71

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:

Reason: Complaint Exit Conference Date: 10/17/2022

Inspection Dates and Department Representative

10/17/2022 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 141 Residents Served: 70

Special Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 69

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

Have Mobility Need: 25 Have Physical Disability: 0

Inspections / Reviews

10/17/2022 - Partial

Lead Inspector: Follow-Up Type: POC Submission Follow-Up Date: 10/03/2022

10/29/2022 - POC Submission

Submitted By: Date Submitted: 10/27/2022

Reviewer: Follow-Up Type: POC Submission Follow-Up Date: 11/03/2022

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Inspections / Reviews (continued)

04/18/2023 - POC Submission

Submitted By: Date Submitted: 11/01/2022

Reviewer: Follow-Up Type: Document Submission Follow-Up Date: 04/18/2023

04/26/2023 - Document Submission

Submitted By: Date Submitted: 04/26/2023

Reviewer Follow-Up Type: Not Required

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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 22, belonging to resident 1 was missing a pill during the narcotic audit at change of shift. The home did not report this incident to the Department.

On 22, belonging to resident 2 was missing a pill during the narcotic audit. The home did report this incident to the Department.

POC Submission

- 10/29/2022)

- 1. During the am narcotic count it was noticed that a pill was missing
- 2. An investigation was done completed
- 3. The Incident Report was not sent because the medication was a PRN and the missing pill did not result in a resident missing a medication, when reviewing the regulation there was no information on missing PRNs so it was not reported.
- 4. The incident reports have both been sent as part of this plan of correction
- 5. The administrator will ensure that any missing narcotics are reported moving forward

Licensee's Proposed Overall Completion Date: 10/26/2022

Implemented (- 04/26/2023)

185a Storage procedures

2. 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

On ______/22, at around ____ pm, the medication treatment cart was left unlocked and unattended in the medication area.

On 22, during the change of shift staff person A was performing the narcotic count and change of shifts with staff person B, at that time was missing a pill from resident 1's narcotic medications. Staff person B does not now what happened to the medication and it was marked on the narcotic count sheet as wasted.

On 22, during the change of shift staff person A was performing the narcotic count and change of shifts with staff person B, at that time was missing a pill from resident 2's narcotic medications. Staff person B does

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185a Storage procedures (continued)

not know what happened to the medication and the count was skipped from 39 to 37. There is no record of what happened to the missing pill.

Plan of Correction Accept 11/03/2022)

- 1. During the am narcotic count it was noticed that a pill was missing
- 2. An investigation was completed and an audit done on all the narcotics, the audit was started on 9/7/22 along with the investigation. The audits have been ongoing and an official audit form was created on 10/14/22 that is attached.
- 3. The Med Tech that left the treatment cart unattended was addressed immediately, the same day as the inspection 10/17/22
- 3. All nurses and med techs received a training on proper medication storage and management. On 10/21/22, training and sign in sheet attached.
- 4. All med techs received a review and in-service on locking unattended carts and the treatment cart having medicated products on 10/21/22, attendance sheet attached.
- 5. Two more keys were requested from pharmacy so each cart can have a key to the treatment cart
- 6. Weekly narcotic audits are completed by the administrator and documented
- 7. Random checks are done to ensure that med and treatment carts are being locked.

Licensee's Proposed Overall Completion Date: 11/07/2022

- 04/26/2023)

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