



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail: [arkmanorpch@gmail.com](mailto:arkmanorpch@gmail.com)  
[bwillner@whitestonehc.com](mailto:bwillner@whitestonehc.com)

MAILING DATE: December 17, 2019

Mr. Ben Willner  
Chief Executive Officer  
Ark Manor, LLC  
105 Sandra Drive  
Delmont, Pennsylvania 15626

RE: Ark Manor  
Certificate #: 446860

Dear Mr. Willner:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 31, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Mazza".

Larry Mazza  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

12/5/2019

### Violation Report

Western Region Field Office  
Bureau of Human Services Licensing

#### Facility Information

Name: **ARK MANOR**  
Address: **105 SANDRA DRIVE,, DELMONT, PA 15626**  
County: **WESTMORELAND**                      Region: **WESTERN**

License Number: **44686**

#### Administration

Name: **Karyn Zayac**                      Phone: **7244686200**                      Email: **BWILLNER@WHITESTONEHC.COM**

#### Legal Entity

Name: **ARK MANOR LLC**  
Address: **105 SANDRA DRIVE, DELMONT, PA, 15626**

#### Certificate(s) of Occupancy

Type: **C-2 LP**                      Date: **06/23/2006**                      Issued By: **L&I**

#### Staffing

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

#### Inspection

Type: **Full**                      BHA Docket #:                      Notice: **Unannounced**  
Reason: **Renewal,Monitoring**

#### Inspection Dates and Department Representative

10/31/2019 - On-Site: **Michael Marini, Amy Duncan, Ashley Roser**

#### Resident Demographic Data as of Inspection Dates

##### General Information

License Capacity: **70**                      Residents Served: **45**

##### Secured Dementia Care Unit

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

##### Hospice

Current Residents: **6**

##### Number of Residents Who

Receive Supplemental Security Income: **14**                      Are 60 Years of Age or Older: **35**  
Diagnosed with Mental Illness: **27**                      Diagnosed with Intellectual Disability: **3**  
Have Mobility Need: **11**                      Have Physical Disability: **0**

82c - Locking Poisonous Materials

Regulations

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

At 9:57 AM, a bottle of nail polish remover, with a manufacture's label indicating, "In case of ingestion ... consult a poison control center", was unlocked, unattended and accessible to residents on resident #1's night stand. Resident #2, who shares a room with resident #1, has been assessed as unsafe around poisonous materials.

At approximately 10:30 AM, a can of WD-40, with a manufacture's label indicating, "Harmful or fatal if swallowed. Induce vomiting. Call a physician immediately", was unlocked, unattended and accessible to residents in bedroom #306.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately on day of inspection the empty bottle of nail polish remover was disposed of. Also on the day of inspection the can of WD-40 was locked up. The resident in private room number 306 is now aware that if she wants to retain any items not suitable for all residents they will need to be in a locked box. A training was done on 12-3-19 with staff on the importance of any poisonous or harmful if swallowed items may not be in any rooms nor in any resident assessed to be safe around them without a locked box. Documentation attached. A walk-through of the home was done the day after inspection to check for anything that shouldn't be in the rooms A walk through will be done bi-weekly to check rooms for any items that should not be there.

See Attachment - 2A

Legal Entity Representative

*Caroline Dunn*

Signature

Caroline Dunn Executive Director 12-4-19

Printed Name and Title

Date

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The above plan of correction is approved as of 12/9/19 (Date)

The above plan of correction was approved by JM (Initials)

Plan of correction implementation status as of 12/13/19 (Date)

Implemented

Not Implemented

102i - Soap Dispenser

Regulations

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was an unlabeled, used bar of soap in the Wing 4 common shower room.

There was an unlabeled, used bar of soap in the common bathroom shared by residents #1, #2, #3 and #4.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately on the day of inspection both bars of soap were thrown in the trash. All residents are encouraged to use the soap the Home provides, but if they choose not to, A labeled container or Ziploc will be provided. A training was done on 12-3-19 on the importance of soaps being used only for the intended resident. All Bathrooms are included on the walk throughs of the Facility to be sure no soaps are left unmarked.

*See Attachment 3A*

Legal Entity Representative

*Caroline Dunn*

Caroline Dunn -Executive Director 12-4-19

Signature

Printed Name and Title

Date

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The above plan of correction is approved as of

12/9/19  
(Date)

Plan of correction implementation status as of

12/13/19  
(Date)

The above plan of correction was approved by

*PM*  
(Initials)

Implemented

Not Implemented

131f - Fire Extinguisher Inspection

Regulations

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the basement was last inspected by a fire safety expert in January 2018.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The inspectors for the fire extinguishers were called and came into the facility on 11-13-19 to inspect the basement extinguisher that had been missed during their annual inspection. All others had been inspected at the correct time. To avoid any extinguisher from being missed in the future Administration composed a list of all extinguishers to be used at the time of the annual inspection and checked off as they are inspected.

Documentation Attachment

...

See Attachments  
4A - 4B

Legal Entity Representative

*Caroline Dunn*

Signature

Caroline Dunn- Executive Director 12-4-19

Printed Name and Title

Date

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(Initials)

Implemented  
 Not Implemented

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill records do not include the exit routes used during the fire drill conducted on 4-29-19 at 5:20 AM.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately on the day of inspection the exit route was written on the fire drill record. Wing 1 exit was used for the fire drill. There were two fire drills for April, and it was overlooked. Moving forward the fire drill record will be reviewed and signed by two people to be sure all blocks are filled in.

See Attachment  
5A

Legal Entity Representative

*Caroline Dunn*

Signature

Caroline Dunn- Executive Director 12-4-19

Printed Name and Title

Date

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The above plan of correction was approved by

*JM*  
(Initials)

Implemented

Not Implemented

183b - Meds and Syringes Locked

Regulations

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 10:19 AM, the following medications were unlocked and accessible in resident #7's bedroom:

- \* Nystatin powder
- \* Fast-Freeze roll-on analgesic
- \* 2 tubes of clotrimazole cream
- \* Z-guard paste

REPEAT VIOLATION: 1/4/2019

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately on the day of inspection, all meds that were in resident #7's room were removed and put in the locked med room. The nystatin and the fast freeze cream, which were expired were disposed of. Resident #7 was made aware that she does not have an order to self administer. A training was done on 12-3-19 to make Staff aware that even if a resident is capable of having the med items in their room (even a private room as in this case), there would be a need for a locked box and a doctor order. Documentation attached. No Residents self administer at this time. If that changes, appropriate steps will be taken. All other rooms were checked for items that are not permissible on 12-12-2019. Monthly rounds for six months will be made ~~with~~

By Administration with documentation

Legal Entity Representative

*Caroline Dunn*

Signature

*Caroline Dunn* 12-12-19  
Caroline Dunn -Executive Director 12-4-19

Printed Name and Title

Date

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The above plan of correction is approved as of 12/12/19  
(Date)

The above plan of correction was approved by LM  
(Initials)

Plan of correction implementation status as of 12/13/19  
(Date)

Implemented

Not Implemented

183d - Prescription Current

Regulations

2600.

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

Description of Violation

The following expired medications were present in resident #7's bedroom:

- \* Nystatin powder, which expired in 8-2019
- \* Fast-Freeze roll-on, which expired in 6-2017

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately on the day of inspection the expired nystatin and fast freeze cream which were in resident #7's room were disposed of. Resident Was made aware that she cannot keep these items in her room without a locked box and a doctor order. It was also explained that they would have to be current. A training was done on 12-3-19 on the importance of checking the rooms and facility for any items that are not permitted, and if they are permitted, should be current and not expired. All stored medications were also checked for good expiration dates. The dates will be checked at the scheduled med card Audits with documentation kept.

*See Attachment 7A*

Legal Entity Representative

*Caroline Dunn*

Signature

Caroline Dunn- Executive Director 12-4-19

Printed Name and Title

Date

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|  |                |   |                 |
|--|----------------|---|-----------------|
| The above plan of correction is approved as of | <u>12/9/19</u> | Plan of correction implementation status as of  | <u>12/13/19</u> |
|  | (Date)         |   | (Date)          |
| The above plan of correction was approved by   | <u>JM</u>      | <input checked="" type="checkbox"/> Implemented |                 |
|  | (Initials)     | <input type="checkbox"/> Not Implemented        |                 |

**185a - Implement Storage Procedures**

**Regulations**

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 #2 is prescribed Albuterol 2.5 mg/3 ml-Use 1 vial in a nebulizer every 4 hours as needed for wheezing or shortness of breath; however, this medication is not available in the home.

Resident #5 is prescribed Novolog-100u/ml-Inject subcutaneously before meals and at bedtime daily in accordance to a sliding scale. However, resident #5's blood glucose readings were not recorded on the resident's October medication administration record (MAR) on the following dates/times:

\* 8:16 PM on 10-23-19

\* 6:43 AM 10-24-19

\* 11:26 AM on 10-24-19

\* 4:40 PM on 10-24-19

Resident #5 is prescribed Novolog-100u/ml-Inject subcutaneously before meals and at bedtime daily in accordance to a sliding scale. Resident #5's blood glucose readings were incorrectly documented on the resident's October 2019 MAR on the following dates and times:

| Date and Time    | Glucometer | October 2019 MAR |
|------------------|------------|------------------|
| 10-19-19 8:22 PM | 171        | 172              |
| 10-30-19 4:15 PM | 136        | 139              |
| 10-31-19 8:32 AM | 196        | 192              |

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately on the day of inspection the PRN albuterol for resident # was ordered and delivered. Resident #5 did have the readings that seemed. to be missing and was treated accordingly but due to her being in the hospital a few days, and a new EMAR system she was not marked back into the facility accordingly. A training was done with the med techs and also a training between the Executive Director, the Pharmacist and the EMAR. programmers to be sure that the easiest system available is used to avoid this from happening in the future. Documentation attached. The EMARS will be monitored weekly by Administration for one month on each person with glucose readings. Monthly thereafter with documentation. <Continued>

*Caroline Durn 1272-19*

Plan of Correction (POC) (continued)

To avoid future problems like this and problems like the one on here for transcribing the wrong readings, a form was made for daily use for each person that needs glucose checks and treatments. This would give something for comparison to be sure that everything is recorded properly, if it would not show up on the EMAR it would still be recorded and treated. All Med Techs were trained on the new system.

Legal Entity Representative



 Caroline Dunn - Executive Director 12-3-19  
 Signature Printed Name and Title Date

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The above plan of correction is approved as of 12/12/19 Plan of correction implementation status as of 12/13/19  
 (Date)  Implemented (Date)  
 The above plan of correction was approved by LM  Not Implemented  
 (Initials)

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

Description of Violation

Resident #5 is prescribed Novolog-100u/ml-Inject subcutaneously before meals and at bedtime daily in accordance to the following sliding scale; >70 - Follow hypoglycemic protocol, then call MD, 120-150=0 units, 151-180=1 units, 181-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, >400=Call MD.

At 7:00 PM on 10-25-19, resident #5's blood glucose was 136, which did not require insulin administration; however, resident #5's October MAR indicates she received 254 units.

At 4:00 PM on 10-26-19, resident #5's blood glucose was 254, which required 4 units of insulin to be administered; however, resident #5's October MAR indicates she received 136 units.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

A training was held on 12-3-19 with the Med Techs to be sure that They understood where to enter the glucose readings and the units being given. The errors were due to the EMAR system being new and the glucose readings and units field being reversed at times. The Med Techs were documenting, but in the wrong field. A New form was made to be used daily for each resident requiring glucose readings and treatments.

Form is attached. A training was also done between the executive director, the pharmacist and the EMAR programmers to develop ways to make the System the best it can be for the facility. Documentation attached. The EMARS will be monitored ~~you~~ <sup>by</sup> Administration weekly for one month on each person with glucose readings. Monthly thereafter with documentation.

Legal Entity Representative

*Caroline Dunn*

Signature

*Caroline Dunn* 12-12-19

Caroline Dunn- Executive Director 12-4-19

Printed Name and Title

Date

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12/12/19

(Date)

Plan of correction implementation status as of

12/13/19

(Date)

The above plan of correction was approved by

*LM*

(Initials)

Implemented

Not Implemented

225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #6's most recent assessment, dated 9-20-19, does not include an assessment of the resident's need for supervision or the resident's need for assistance with medications. These sections of the assessment are blank.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately on the day of inspection the two blanks on resident #6's assessment were assessed and filled in. All other RASPS were reviewed and will be reviewed monthly by Administration for any blank spaces or missing information. Documentation will be kept at the front of the Resident file.

See Attachment 11A

Legal Entity Representative

*Caroline Dunn*

Caroline. Dunn -Executive Director 12-4-19

Signature

Printed Name and Title

Date

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(Date)

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(Date)

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(Initials)

Implemented

Not Implemented