Department of Human Services
Bureau of Human Service Licensing

February 6, 2022

[redacted], PRESIDENT-CEO

RE: TUNKHANNOCK MANOR
50 WEST TIOGA STREET
TUNKHANNOCK, PA, 18657
LICENSE/COC#: 23655

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/28/2021, 09/29/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *TUNKHANNOCK MANOR* **License #**: *23655* **License Expiration**: *12/08/2021*

Address: *50 WEST TIOGA STREET, TUNKHANNOCK, PA 18657*

County: *WYOMING* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/27/1994* **Issued By**: *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *34* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/29/2021*

Inspection Dates and Department Representative

09/28/2021 - On-Site:

09/29/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

09/28/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/09/2021*

01/18/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/21/2022*

01/22/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/26/2022*

02/06/2022 - Document Submission

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The home's most recent LIS report from their annual renewal inspection dated 09/23/19 was posted with the resident privacy code.

Plan of Correction ***Accept***

The Posting with the residents name was removed. Any further postings will be reviewed by Administration before being posted. All Postings will also be apart of our Quality Control Check during our QAPI Survey.

Document Submission ***Implemented***

Attached is where the resident name was posted and it was removed.

65b - Rights/Abuse 40 Hours

1. Requirements

2600.

65.b. 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.

Description of Violation

Staff Person "A" DOH [redacted], did not have proof that they received training for the first 40 hours for resident rights, Mandatory reporting of abuse, OAPSA, reportable incidents and conditions as required by this regulation.

Plan of Correction ***Accept***

In-service conducted with Staff Person A on Relias as well as in person with the Administrator and Staff Development Coordinator.

Staff Development Coordinator to ensure all orientation training is completed within the 40 hour scheduled working hours. Administrator/Designee to monitor/ensure ongoing compliance.

Update: *01/18/2022*

Please send/Attach proof of staff training. 1-18-2022 MM

Document Submission ***Implemented***

Attached is the signed Acknowledgement on Staff person A and their trainings.

107a - Emergency Preparedness

1. Requirements

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

107a - Emergency Preparedness *(continued)*

Description of Violation

The home did not have available, a copy of the emergency plan for the municipality in which the home is located.

Plan of Correction ***Do Not Accept***

Obtained the Emergency Preparedness Plan for the municipality and it has been reviewed and posted.

Update: *01/18/2022*

Please include in plan of correction, who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen. 01-18-2022 MM

Plan of Correction ***Accept***

The Administrator of Tunkhannock Manor is responsible for obtaining/reviewing the Emergency Preparedness Plan from the Municipality. The Administrator is responsible to review the plan annually The Administrator will also go over the plan annually with all staff and residents. The Administrator is responsible to monitor to ensure ongoing compliance.

Document Submission ***Implemented***

Attached is the Emergency Preparedness Plan that is gone over with the Wyoming County Emergency Management Agency. This Plan is reviewed Annually with staff and residents.

124 - Notice to Fire Department

1. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home's letter to the local fire department dated 08/16/2019 stated that the home had no immobile residents. The home presently has 1 immobile resident and would need assistance to evacuate in the event of an emergency. Documentation of notification shall be kept

Plan of Correction ***Do Not Accept***

An updated letter was sent to the local fire department. Contents of the letter are location of rooms, locations of immobile residents and what assistance is needed in the event of an emergency or evacuation. Further action will be a monthly Resident audit completed by the administrator for any resident changes that will need the local fire department notified.

Update: *01/18/2022*

Please include in plan of correction, who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen. 01-18-2022 MM

Plan of Correction ***Accept***

The Administrator will review residents on monthly basis. If a residents condition changes to a immobile status, a letter will be sent to the local fire department identifying the resident room number and location of where the immobile resident is located for emergency responders to quickly locate and evacuate if necessary. The Administrator is responsible to monitor and ensure ongoing compliance.

Update: *01/22/2022*

Please send/Attach proof of compliance (letter) - 1-22-2022 MM

124 - Notice to Fire Department *(continued)*

Document Submission ***Implemented***

Attached is the letter that was sent to the local fire department.

141b1 - Annual Medical Evaluation

1. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The following annual DME’s were reviewed for Residents #1, #2, #3, #4, #5 and #6. The DME's did not indicate if the residents were able to safely use or be around poisonous substances.

Plan of Correction ***Do Not Accept***

Our physician partners have been notified and educated on indicating if the resident were able to safely use or be around poisonous substances on the annual DME's. Further action QAPI will audit 2 a month for the next 6 months to make sure this is being completed.

Update: *01/18/2022*

Please include in plan of correction, who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen. 01-18-2022 MM

Plan of Correction ***Accept***

The Administrator and LPN Supervisor have corrected the identified DME's. The Administrator and the LPN Supervisor will be responsible for reviewing DME's after being completed by the physician to ensure completion and accuracy. Audits will be completed every 2 months for the next 6 months to ensure compliance. Administrator and LPN Supervisor to ensure ongoing compliance.

Document Submission ***Implemented***

The Administrator and LPN supervisor will continue to ensure ongoing compliance.