



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: August 5, 2022

[REDACTED]
TLC Healthcare, LLC
[REDACTED]

RE: Dunlevy Manor
2218 Route 88
Dunlevy, Pennsylvania 15432
License/COC #: 447544

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 8, 2022, February 9, 2022, February 10, 2022, February 11, 2022, and May 16, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FOURTH PROVISIONAL license to operate the above facility. A FOURTH PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4); (relating to conditions for denial, nonrenewal or revocation). Your FOURTH PROVISIONAL license is enclosed and is valid from August 5, 2022 to February 5, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
141(a)	II	16	\$5	\$80	5 calendar days from mailing date of this letter
187(b)	II	16	\$5	\$80	5 calendar days from mailing date of this letter
187(d)	II	16	\$5	\$80	5 calendar days from mailing date of this letter
225(a)	II	16	\$5	\$80	5 calendar days from mailing date of this letter
225(c)	II	16	\$5	\$80	5 calendar days from mailing date of this letter
227(a)	II	16	\$5	\$80	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

Your facility's FOURTH PROVISIONAL license will expire on 2/5/2023. Pursuant to 55 Pa. Code § 20.54, a maximum of four consecutive provisional certificates of compliance may be issued to the legal entity for each specific facility or agency (1 Pa. Code. Part II).

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Jeanne Parisi, Bureau Director
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

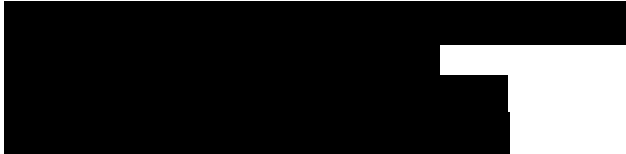
Sincerely,



Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *DUNLEVY MANOR* License #: *44754* License Expiration: *05/23/2022*
Address: *2218 ROUTE 88, DUNLEVY, PA 15432*
County: *WASHINGTON* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7243265611* Email: [REDACTED]

Legal Entity

Name: *TLC HEALTHCARE LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/20/1996* Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *21* Waking Staff: *16*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Interim* Exit Conference Date: *05/16/2022*

Inspection Dates and Department Representative

05/16/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* Residents Served: *16*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *16*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *5* Have Physical Disability: *0*

Inspections / Reviews

05/16/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/02/2022*

06/14/2022 - POC Submission

Inspections / Reviews *(continued)*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *06/16/2022*

06/29/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type:

Follow-Up Date:

63a - First Aid/CPR Training

1. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 5/2/22, during the 11:00 p.m. to 7:00 a.m. shift, there were 16 residents were present in the home. During this time, direct care staff persons A and B were the only two staff persons working in the home. Neither staff person is certified in first aide/CPR.

Plan of Correction

Accept

Staff person A completed First aide/CPR prior to 5/2/22, but did not sign in on the course roster at the time of the class. Going forward, the administrator/designee will ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times. Administrator/designee with review schedule monthly to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Completion Date: 06/21/2022

Licensee's Proposed Date for POC Implementation

6/29/22 JK

Not Implemented

89b - Hot Water Temperature

1. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 5/16/22 at approximately 9:55 a.m., the sink water temperature in the large common shower/tub room measured 137.3 degrees Fahrenheit.

On 5/16/22 at approximately 9:58 a.m., the sink water temperature in the Jack and Jill shared bathroom between bedrooms #1 and #2 measured 136.9 degrees Fahrenheit.

On 5/16/22 at approximately 10:00 a.m., the sink water temperature in the Jack and Jill shared bathroom between bedrooms #3 and #4 measured 140.2 degrees Fahrenheit.

On 5/16/22 at approximately 10:50 a.m., the sink water temperature in the Jack and Jill shared bathroom between bedrooms #11 and #12 measured 136.2 degrees Fahrenheit.

On 5/16/22 at approximately 10:30 a.m., the sink water temperature in the Jack and Jill shared bathroom between bedrooms #9 and #10 measured 129.0 degrees Fahrenheit.

On 5/16/22 at approximately 10:30 a.m., the sink water temperature in the Jack and Jill shared bathroom between bedrooms #7 and #8 measured 127.0 degrees Fahrenheit.

On 5/16/22 at approximately 10:50 a.m., the sink water temperature in the Jack and Jill shared bathroom between bedrooms #5 and #6 measured 136.2 degrees Fahrenheit.

Plan of Correction

Accept

Thermostats on the water heater were found to be faulty, New thermostats to control the water temperature were installed on the water heater, bringing the temperature below 120 degrees. Administrator or designee with

89b - Hot Water Temperature (continued)

monitor water temperatures weekly to ensure hot water temperature in areas accessible to the resident do not exceed 120°F.

Completion Date: 05/30/2022 Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

101j1 - Mattress Fire Retardant

1. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 5/16/22, resident # [redacted] green vinyl mattress in bedroom #3, has long cracks down the middle exposing the white threading and foam padding to include a crack measuring approximately 7" long and one approximately 6" long.

On 5/16/22, resident # [redacted] green vinyl mattress in bedroom #7, has two holes in top middle of mattress, measuring approximately 1 1/2" in diameter and the other approximately 1" in diameter, from the springs poking through the vinyl.

Plan of Correction Accept

Mattresses from bedrooms #3 and # 7 were disposed of and mattresses that are in good repair, clean, support the resident and are fire retardant were placed on the bedframes. The administrator or designee will check mattresses weekly to ensure they are fire retardant mattress that is in good repair, clean and supports the resident.

Completion Date: 05/18/2022 Licensee's Proposed Date for POC Implementation 6/29/22 JK

Not Implemented

102i - Soap Dispenser

1. Requirements

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

On 5/16//22 at approximately 10:50 a.m., the Jack and Jill shared bathroom between bedrooms #5 and #6 did not have a dispenser of soap.

Plan of Correction Accept

A soap dispenser was placed in the bathroom between bedrooms #5 and #6. The administrator or designee with ensure all bathrooms have dispenser with soap shall be provided within reach of each bathroom sink. Bar soap will not be permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Administrator/designee will verify all bathrooms have dispenser with soap weekly

Completion Date: 06/21/2022 Licensee's Proposed Date for POC Implementation 6/29/22 JK

Not Implemented

132c - Fire Drill Records

1. Requirements

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.

132c - Fire Drill Records (continued)

Description of Violation

Resident #3 was admitted to the home on [REDACTED] 22 and requires the use of a Hoyer lift to transfer. The home conducted fire drills on 4/6/22 at 9:45 a.m. and 5/9/22 at 6:00 a.m. The resident remained in [REDACTED] room and was not evacuated for either fire drill. The homes fire drill record indicates all residents were evacuated for both fire drills.

Plan of Correction

Directed

A fire drill was conducted on 5/26/22 Resident # 3 and all residents were evacuated during the fire drill. All staff were educated on 2600.132.c to include all written fire drill records 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. The administrator or designee will ensure written fire drill records 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. A fire drill is scheduled in conjunction with the local fire department on 6/24/22 with a fire safety education to follow. All residents will be evacuated during the drill

DIRECTED

Within five calendar days of the receipt of the accepted plan of correction: The administrator shall audit the fire drill record monthly to ensure compliance with regulation 2600.132(c). 6/28/22 JK

Completion Date: 06/24/2022 **Licensee’s Proposed Date for POC Implementation**

6/29/22 JK

Not Implemented

132d - Evacuation

1. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

Resident #3 was admitted to the home on [REDACTED] 22 and requires the use of a Hoyer lift to transfer. The home conducted fire drills on 4/6/22 at 9:45 a.m. and 5/9/22 at 6:00 a.m. The resident remained in [REDACTED] room and was not evacuated for either fire drill.

Plan of Correction

Directed

A fire drill was conducted on 5/26/22 Resident # 3 and all residents were evacuated during the fire drill. All staff were educated on 2600.132.c to include all written fire drill records 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. The administrator or designee will ensure written fire drill records 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. A fire drill is scheduled in conjunction with the local fire department on 6/24/22 with a fire safety education to follow. All residents will be evacuated during the drill.

DIRECTED

Within five calendar days of the receipt of the accepted plan of correction: The administrator shall audit fire drills

132d - Evacuation (continued)

monthly for at least three months, including a sleeping hour fire drill, to ensure compliance with regulation 2600.132(d). 6/28/22 JK

Completion Date: 06/24/2022 Licensee's Proposed Date for POC Implementation 6/29/22 JK

Not Implemented

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

Resident #2 was admitted to the home on [redacted] 2020. The resident's most recent medical evaluation was completed on [redacted] 21.

Resident #4 was admitted to the home on [redacted] 16, The resident's most recent medical evaluation was completed on [redacted] 21.

Plan of Correction

Directed

A record review/audit was completed to ensure all medical evaluations are completed at least annually. Staff were educated on annual medical evaluations. Going forward, Administrator/designee will audit resident files monthly to ensure a medical evaluation is completed within 60 days prior to admission or within 30 days after admission.

DIRECTED

Within five calendar days of the receipt of the accepted plan of correction: The administrator or designated staff person shall develop and implement a system to ensure residents have an in person medical evaluation completed at least annually. 6/28/22 JK

Completion Date: 06/23/2022 Licensee's Proposed Date for POC Implementation 6/29/22 JK

Not Implemented

185a - Implement Storage Procedures

1. Requirements

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 #5 is prescribed blood glucose checks twice a day (9:00 a.m. and 8:00 p.m.). On 5/16/22, the resident's May 2022 MAR was not accessible. The home recorded the blood glucose readings on a document labeled, "Glucometer Log".

However, on multiple dates and times, the blood glucose readings recorded on the Glucometer Log are not indicated on either of the resident's glucometers (old Contour Next EZ or new AgaMatrix AMP), as follows:

- 5/10/22 at 8:00 p.m. Glucometer log indicates 149-No reading on the glucometer
- 5/11/22 at 8:00 p.m. Glucometer log indicates 125- No reading on the glucometer
- 5/12/22 at 9:00 a.m. Glucometer log indicates 144 -No reading on the glucometer
- 5/12/22 at 8:00 p.m. Glucometer log indicates 98- No reading on the glucometer
- 5/13/22 at 9:00 a.m. Glucometer log indicates 122- No reading on the glucometer
- 5/13/22 at 8:00 p.m. Glucometer log indicates 110- No reading on the glucometer
- 5/14/22 at 9:00 a.m. Glucometer log indicates 206- No reading on the glucometer

Resident #6's glucometer is not set to the correct date and time, indicating a date of 7/17 and a time of 4:05 a.m.. The

185a - Implement Storage Procedures (continued)

actual date 5/16/22 and time 11:55 a.m.

Resident #6 is prescribed blood glucose readings to be completed twice a day, before meals. On 5/16/22, the resident's May 2022 MAR was not accessible. The home recorded the blood glucose readings on a document labeled, "Glucometer Log". However, on multiple dates and times, the blood glucose readings recorded on the Glucometer Log are not indicated on the resident's glucometer, as follows:

- 5/9/22 AM Glucometer log indicates 109 -No reading on the glucometer.
- 5/9/22 PM Glucometer log indicates 200-No reading on the glucometer
- 5/10/22 AM Glucometer log indicates 118-No reading on the glucometer
- 5/10/22 PM Glucometer log indicates 176-No reading on the glucometer
- 5/11/22 AM Glucometer log indicates 117-No reading on the glucometer
- 5/11/22 PM Glucometer log indicates 140-No reading on the glucometer
- 5/12/22 PM Glucometer log indicates 157-No reading on the glucometer
- 5/13 /22 PM Glucometer log indicates 130-No reading on the glucometer

Plan of Correction

Directed

All staff were educated on the procedures for the safe storage, access, security, distribution and use of medications and medical equipment to include glucometers. Glucometers will be discussed at each QA meeting. Going forward, ordered glucometer reading will be documented on the MAR and a glucometer log. The administrator/designee will ensure compliance with safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. This will be done daily and documented on a checklist.

DIRECTED

Within five calendar days of the receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications and insulin medications shall complete a weekly audit of medication and insulin medication administration records to ensure the proper administration and documentation of medications including insulin medications. 6/28/22 JK

Completion Date: 06/15/2022 Licensee's Proposed Date for POC Implementation

6/29/22 JK

Not Implemented

225a - Assessment 15 Days

1. Requirements

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 #3 was admitted to the home on [REDACTED] 22. An initial assessment has not been completed for this resident.

Resident #6 was admitted to the home on [REDACTED] 22. An initial assessment has not been completed for this resident

Plan of Correction

Accept

An audit was completed for all records to ensure documentation was completed of initial assessment. Staff were educated on initial assessments. A monthly audit will be completed by the Administrator or designee monthly to ensure that residents have a written initial assessment that is documented on the Department's assessment form within 15 days of admission.

225a - Assessment 15 Days (continued)

DIRECTED

Within 15 calendar days of receipt of the accepted plan of correction: The administrator or designated staff person shall complete an assessment for residents #3 and #6. 6/29/22 JK

Completion Date: 06/20/2022 Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

225c - Additional Assessment

1. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

Description of Violation

Resident #2 was, admitted to he home on [redacted] 2020. The residents most recent assessment was completed on [redacted] 21.

Resident #4 was admitted to the home on [redacted] 16. The residents most recent assessment completed is dated, [redacted] 21.

Resident #7 was admitted to the home on [redacted] 15. The residents most recent assessment completed is dated, [redacted] 20.

Plan of Correction

Directed

A record review/audit was completed to ensure all additional assessments are completed at least annually. Going forward, Administrator/designee will audit resident files monthly to ensure a medical evaluation is completed annually.

DIRECTED

Within 15 calendar days of receipt of the accepted plan of correction: The administrator or designated staff person shall complete an assessment for residents #2, #4 and #7. 6/29/22 JK

Completion Date: 06/07/2022 Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

227a - Support Plan 30 Days

1. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #3 was admitted to the home on [redacted] 22. An initial support plan has not been completed for this resident.

Resident #6 was admitted to the home on [redacted] 22. An initial support plan has not been completed for this resident.

Plan of Correction

Accept

support plans have been completed for residents # 3 and # 6. An audit of all records was completed to ensure completion of Going forward the administrator or designee will ensure weekly that residents requiring personal care services will have a written support plan developed and implemented within 30 days of admission to the home and document his on a checklist. The support plan will be documented on the Department's support plan form.

Completion Date: 06/20/2022 Licensee's Proposed Date for POC Implementation 6/29/22 Not Implemented

227i - Support Plan Accessible

1. Requirements

2600.

227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On 5/16/22, none of the current resident support plans were accessible to direct care staff. The support plans are not present or available in the resident records. The support plans are only accessible via computer and there was no internet available from 9:00 a.m. to 3:00 p.m. This is a regular occurrence.

Plan of Correction

support plans have been printed and are accessible to staff persons at all times. Going forward, the administrator or designee will ensure weekly that support plans are accessible to staff persons.

Accept

Completion Date: 05/30/2022

Licensee's Proposed Date for POC Implementation

6/29/22 JK

Not Implemented