CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: August 10, 2022

Ark Manor LLC
105 Sandra Drive
Delmont, Pennsylvania 15626

RE: Ark Manor
105 Sandra Drive
Delmont, Pennsylvania 15626
License/COC #: 446861

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 2, 2021, November 3, 2021, November 8, 2021, November 16, 2021, November 17, 2021, February 15, 2022, February 16, 2022, February 17, 2022, February 23, 2022, February 24, 2022, February 25, 2022, March 14, 2022, March 30, 2022, May 2, 2022, May 3, 2022, June 8, 2022, June 9, 2022, and June 10, 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 REVOKES your certificate of compliance (license number 446860) dated February 19, 2022 – February 19, 2023, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 10, 2022 to February 10, 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 Section:	Class of Violation	Census at Inspection X	Fine Per resident Per day	= Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
15(a)	II	30	$5	$150	5 calendar days from mailing date of this letter
16(c)	II	30	$5	$150	5 calendar days from mailing date of this letter
42(b)	II	30	$5	$150	5 calendar days from mailing date of this letter
95	II	30	$5	$150	5 calendar days from mailing date of this letter
141(a)	II	30	$5	$150	5 calendar days from mailing date of this letter
183(b)	II	30	$5	$150	5 calendar days from mailing date of this letter
187(b)	II	30	$5	$150	5 calendar days from mailing date of this letter
225(a)	II	30	$5	$150	5 calendar days from mailing date of this letter
225(c)	II	30	$5	$150	5 calendar days from mailing date of this letter
227(c)	II	30	$5	$150	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.

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: [redacted]

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

Facility Information

Name: *ARK MANOR* **License #**: *44686* **License Expiration**: *02/19/2023*

Address: *105 SANDRA DRIVE, DELMONT, PA 15626*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *7244686200* **Email**: [redacted]

Legal Entity

Name: *ARK MANOR LLC*

Address: *105 SANDRA DRIVE, DELMONT, PA, 15626*

Phone: *7244686200* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/2006* **Issued By**: *Dept of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *06/10/2022*

Inspection Dates and Department Representative

06/08/2022 - On-Site: [redacted]
06/09/2022 - Off-Site: [redacted]
06/10/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served**: *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *6* **Are 60 Years of Age or Older**: *26*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

06/08/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/02/2022*

Inspections / Reviews *(continued)*

07/08/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/11/2022*

07/21/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/31/2022*

07/27/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type:** *Exception* **Follow-Up Date:**

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 6/8/22, multiple staff interviews indicated resident #1 had reported multiple times to staff, including direct care staff person A, that resident #2 kept coming into resident #1's bedroom yelling at the resident, accusing the resident of being in the wrong room, the bed wasn't [redacted] and that resident #1 needed to get out. Documentation in the Staff Communication Log on 5/12/22, during the midnight shift (10:00 p.m. to 6:00 a.m.) indicated the following, "Resident #2 got confused and was trying to get stuff out of resident #1's room." Resident #3 reported on several occasions witnessing resident #2 yell at resident #1 about being in the wrong room and telling resident #1 to get out. Resident #3 indicated resident #1 repeatedly said [redacted] didn't like being yelled at and poked by resident #2, was afraid of the resident, did not feel safe there and wanted to leave the home. Resident interviews indicated resident #1 talked about barricading self in bed at night with wheelchair and walker to prevent resident #2 from "getting to" resident #1 while sleeping. Resident #1 did not feel safe and wanted to leave the home. On [redacted]/22, resident #1 moved out of the home with the assist of family. The home did not report the allegation of abuse to the Department.

Plan of Correction ***Directed***

Staff reeducated on 2600.16 (attachment A) and educated on the importance that all incidents/ allegations of abuse must be reported to administration immediately. Administration will report all incident to the department immediately. Administration will privately interview one resident per week for 6 months so resident can privately discuss any issues with administraition. Documentation will be kept (attachment H) reportable incident for 5/12/22 sent to DHS as part of plan of correction. (attachment G)

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator designated staff person shall audit all reportable incidents and conditions to ensure any reportable incidents and conditions are reported in accordance with regulation 2600. 16(c). 7/19/22 JK

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation

7/27/22 JK
Not Implemented

42b - Abuse

1. Requirements

2600.
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

On 6/8/22, multiple staff interviews indicated resident #1 had reported multiple times to staff, including direct care staff person A, that resident #2 kept coming into resident #1's bedroom yelling at the resident, accusing the resident of being in the wrong room, the bed wasn't [redacted] and that resident #1 needed to get out. Documentation in the Staff Communication Log on 5/12/22, during the midnight shift (10:00 p.m. to 6:00 a.m.) indicated the following, "Resident #2 got confused and was trying to get stuff out of resident #1's room." Resident #3 reported on several occasions witnessing resident #2 yell at resident #1 about being in the wrong room and telling resident #1 to get out. Resident #3 indicated resident #1 repeatedly said [redacted] didn't like being yelled at and poked by resident #2, was afraid of the resident, did not feel safe there and wanted to leave the home. Resident interviews indicated resident #1 talked about barricading self in bed at night with wheelchair and walker to prevent resident #2 from "getting to" resident #1 while sleeping. Resident #1

42b - Abuse (continued)

did not feel safe and wanted to leave the home. On [redacted]/22, resident #1 moved out of the home with the assist of family.

Resident #4's assessment and support plan, dated [redacted]/21, indicate the resident requires minimal supervision "Resident needs some direction, at times. In the home but would need supervised when out in unfamiliar places." and "Staff will continue with regular checks in the home and redirect when needed. Family will supervise when outside the facility." The resident's support plan indicates "Moderate problem with orientation to time place and person." and "Periods of confusion easily re-orients." However, the support plan does not indicate the frequency of the supervision checks. Resident #4's medical evaluation, [redacted]/21 indicates a diagnosis of dementia and mood disorder with cognitive functioning indicated as, "poor". Interviews indicated since the resident was discharged from the hospital on [redacted]/22 following [redacted] the resident does not walk around as previously did, needs guided by hand with verbal cueing from place to place often with redirection.

On [redacted]/22, at approximately [redacted] p.m., direct care staff person B was unable to locate resident #4 in the home. After searching for resident #4 staff person B called staff person C, who was not working at the time, informing the staff person that resident #4 could not be found. The resident was said to be last seen at approximately [redacted] p.m. or [redacted] p.m., sitting in the living room. Resident #4 was found approximately 800 feet from the home. The local EMS agency was called and transported the resident to the hospital with [redacted] Resident was placed [redacted] in emergency department for [redacted] The resident was moved from ICU and placed [redacted]

Plan of Correction ***Directed***

part 1- all support plans will be reviewed by administration within 30 days for accuracy including behavioral issues. Staff re educated to provide positive interventions. (attachment B) Administration will privately interview one resident per week for 6 months to ensure no abuse is occuring. Documention will be kept. (attachment H)

part 2- all support plans will be reviewed by administration within 30 days for accuracy including supervision needs. Staff re educated on each resident's supervision needs (attachment C) and will provide the proper supervison . Policy and procedure to locate a resident created and staff educated on the policy and procedure. (attachments D and F)

DIRECTED
Within 10 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a system of communication to ensure all staff persons are aware of residents who may display inappropriate behaviors, such as touching other residents, as well ensuring all staff persons are aware of any residents who are exit-seeking. All staff persons shall be educated on the new system. Documentation of the education shall be kept. 7/19/22 JK

Within 7 calendar days of receipt of the plan of correction: The home shall create an interdisciplinary team to review and discuss levels of supervisions and resident behaviors, such as inappropriate touching, exit-seeking behaviors and other internal incidents to ensure residents are not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. The interdisciplinary team shall meet at least monthly and consist of at least 2 direct care staff persons. Resident assessments and support plans shall immediately be updated as needed immediately following the monthly review. Documentation of the reviews shall be kept, which includes the date of the review, who attended the review and what was discussed. 7/19/22 JK

Within 5 calendar days of receipt of the plan of correction, then monthly thereafter: A designated staff person shall

42b - Abuse (continued)

interview at least 3 residents in private to ensure residents are not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. Documentation of the interviews shall be kept. 7/19/22 JK

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 JK

Not Implemented

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person D, hired [redacted]22 and first day [redacted]22, does not have a high school diploma, GED, or active registration status on the Pennsylvania nurse aide registry. Direct care staff person D performed unsupervised personal care services, to include medication administration to residents in the home, including resident #4 and #5, on the following dates and times, including:
Resident #4
** On 6/1/22, administered, Dorzolamide-Timolol eye drops and removed Ted hoes at bedtime at 8:00 p.m.*
** On 6/3/22 and 6/4/22., at 7:00 p.m., administered Carbidopa-Levodopa 10-100 tablet, Gabapentin 300mg tablet; Quetiapine Fumarate 200mg tablet; Latanoprost 0.005% eye drop ; Mirtazapine 15mg tablet*

Resident #5
** On 6/1/22, 6/5/22 and 6/6/22 at 5:00 p.m., was administered Metformin HCL 500mg and Glipizide 5mg.*
** On 6/1/22, 6/5/22 and 6/6/22, at 8:00 p.m., was administered -Eliquis 5 mg; Gemfibrozil 600mg; Metformin HCL 500mg; Pravastatin Sodium 40mg; Trazadone 50mg and Lantus Solostar 100 unit/ML injected 15 units at bedtime.*

Plan of Correction ***Directed***

Staff person D is currently enrolled in a GED course and will provide no direct care until obtained and all qualifications are met.

All current staff charts reviewed by administration to ensure all staff providing care meet qualifications.

The facility disputes this allegation because as stated in 2600.190 Medication administraion training.
(a) A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.
(b) A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.
(c) A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall review all direct care

54a - Direct Care Staff (continued)

staff qualifications to ensure all direct care staff persons meet the requirements of Regulation 2600.54(a) prior to providing any unsupervised direct care services. 7/19/22 JK

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 JK

Not Implemented

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

On 6/5/22, the home was providing services to 28 residents. Direct care staff person B, hired [redacted]22, provided unsupervised personal care services to the residents in the home on 6/5/22. There is no documentation to indicate direct care staff person B has completed the Department-approved direct care training course and passed the competency test.

Plan of Correction ***Accept***

Staff person B successfully completed direct care training course and passed the compentency test prior to provided any further unsupervised ADL services.
Moving forward, all new employees will complete course and compentency tests prior to providing any unsupervised ADL services for the residents. completion certificate will properly be put into staff's employee chart.

All current staff charts reviewed by administration to ensure all staff providing care meet qualifications. No staff will provide care before course is complete and certificate is in their record.

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 JK

Not Implemented

130g - Smoke Detector Repair

1. Requirements

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 6/5/22, the home's main fire panel and the Remote Annunciator box were both indicating "Trouble". Information provided indicates the fire alarm systems smoke detectors and pull stations have been malfunctioning for some time. Interviews indicating a fire drill conducted in March 2022, where the one smoke detector in the blue hall malfunctioned.

Plan of Correction ***Directed***

Owner has reached out to vendor for repair/ replacement. Aiming for repair/ replacement to be completed by August 15, 2022. Administration will notify DHS in any delays.

DIRECTED
Within 15 calendar days of receipt of the accepted plan of correction: The administrator or designated person shall educate all staff persons to identify when the fire alarm system is in trouble and the home's policy and procedures for reporting issues and contacting the fire alarm company to assess and repair the system. Documentation of education shall be kept. 7/19/22 JK

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 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's annual assessment, dated [redacted]/22, does not include an assessment for supervision or medication administration. These sections are blank.

Plan of Correction ***Directed***

all support plans will be reviewed by administration within 30 days to ensure accuracy. designated person will perform second review to ensure all areas are accurate and completed entirely.

The blank sections are completed for resident #2.
Moving forward, annual assessments will be closely monitored to ensure all appropriate areas are accurately completed.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall review all newly completed assessments to ensure accuracy and completeness. 7/19/22 JK

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 JK
Not Implemented

227c - Support Plan Revision

1. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #2's support plan indicates the resident does well in the home but needs supervision outside of the facility. The plan to meet the supervision needs of the resident: Staff will continue with routine checks minimally of every 2 hours. The resident is assessed with moderate needs of being orientated to time, place and person, the support plan indicates the resident has moderate periods of confusion, but easily directed. The support plan is not updated to reflect the residents recent reported behaviors of resident #2, where the resident has been targeting resident #1 for being in the wrong bed or room on a regular basis. Also, resident #2 allegedly hit resident #1 with the resident's clothes grabber. The staff communication log indicated on [redacted]/22, during the overnight shift (10:00 p.m. to 6:00 a.m.).

Plan of Correction ***Directed***

Resident #2's support plan udated to reflect current needs.

all support plans will be reviewed by administration within 30 days to ensure accuracy. designated person will perform second review to ensure all areas are accurate and completed entirely.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall review all newly completed support plans to ensure accuracy and completeness. 7/19/22 JK

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 JK
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

Multiple staff interviews conducted on 6/8/22 and 6/9/22, reported having no knowledge of what a resident's assessment or support plan was, what they looked like or where to access them.

Plan of Correction ***Accept***

A binder has been created with all current resident's support plans. The binder is accessible by DCS at all times and staff has been reeducated. All DCS aware of the location of the binder. (attachment E) It will be updated as needed. administration will check the binder weekly to ensure it remains in the appropriate place.

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 JK

Not Implemented

252 - Record Content

1. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.

Description of Violation

Resident #1 was admitted to the home on [redacted]/21 and was discharged on [redacted]22. However, there is no documentation of the discharge date or destination, or reason resident vacated the home.

Plan of Correction ***Accept***

Appropriate documentation added to resident #1's chart.
Moving forward, this information will be documented in the resident's chart at the time of discharge. Administration will review this information after a resident's discharge to ensure all is documented appropriately. (The reason for termination of services or transfer of the resident, the date of transfer and the destination.)

Completion Date: *07/15/2022* Licensee's Proposed Date for POC Implementation 7/27/22 JK

Not Implemented