pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE:

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) review on July 20, 2022 of the above facility, we have determined that your submitted plan of correction is not implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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**: [redacted] **Email**: [redacted]

Legal Entity

Name: *ARK MANOR LLC*

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

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

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *27* **Waking Staff**: *20*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *07/20/2022*

Inspection Dates and Department Representative

07/20/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served**: *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *14* **Are 60 Years of Age or Older**: *21*

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

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

07/20/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/06/2022*

08/12/2022 - POC Submission

Inspections / Reviews *(continued)*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/18/2022*

08/19/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/19/2022*

09/28/2022 - 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 /22, staff person A, , received a report of a verbal altercation between residents #1 and #2. On /22, staff person A received a report from a resident's family member indicating that during the verbal altercation between residents #1 and #2 on /22, resident #1 pushed resident #2, which made resident #2 fall onto his bed. However, this incident was not reported to the Department until an agent of the Department was on-site on 7/20/22, and the written incident report was not submitted to the Department until 7/26/22.

For approximately 1 year, multiple residents have repeatedly and routinely made racial slurs and vulgar comments to resident #1; however, none of these incidents were reported to the Department.

REPEAT VIOLATION: 11/02/2021, et. al.

Plan of Correction ***Directed***

-resident education meeting scheduled with obudsman for 08/16/2022 at 10:00am. topic- resident's rights
-Additional training with staff completed on all topics specified under 2600.16a. training done on 8/13/2022.
-To ensure all reportable incidents under 2600.16a are reported to the department within 24 hours additional staff educated on the procedure to report. education done on 8/13/2022.
documentation of training will be kept.

DIRECTED: Within 3 calendar days of receipt of the plan of correction: A designated staff person shall submit an incident report to the Department related to the routine racial slurs that have been made towards resident #1 for approximately the past year. 8/15/22

DIRECTED: Within 3 calendar days of receipt of the plan of correction: A designated staff person shall review all internal incidents and conditions daily to ensure all incidents indicated in 2600.16a are reported to the Department within 24 hours. Copies of all incident reports submitted to the Department shall be kept. 8/15/22

Completion Date: *08/14/2022*

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 /22 at approximately p.m., a verbal altercation occurred between residents #1 and #3 near the large outdoor gazebo. During the altercation, resident #1 pushed resident #3 on the upper chest with both hands, causing resident #3 to fall backwards and hit head on the stones. Emergency services responded and transported resident #3 to the hospital, where resident #3 treated for multiple injuries, to include multiple cervical fractures.

42b - Abuse (continued)

For approximately 1 year, multiple residents, to include residents #2 and #3, have repeatedly and routinely made racial slurs and vulgar comments to resident #1.

REPEAT VIOLATION: 11/02/2021, et. al.

Plan of Correction ***Directed***

Residents 1, 2 and 3 are stil in the home. resident 1 no longer has meals with/ near resident 2 and 3. (sits in the opposite diningroom) Staff closely supervising to ensure no further issues arrise.
-resident education meeting scheduled with obudsman for 08/16/2022 at 10:00am. topic- resident's rights (DIRECTED: Documentation of the resident meeting shall be kept. ██ 8/15/22).
-administration or designated person will file a report if any resident is neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

DIRECTED: By 8/31/22: All staff persons shall be educated on all resident rights, which includes the residents' right to be free from abuse and neglect. The training shall include the use of positive interventions to modify or eliminate behaviors in accordance with 2600.201, which includes ensuring residents are free from verbal/physical abuse and racial slurs. Documentation of the education shall be kept. ██ 8/15/22

DIRECTED: By 8/31/22: The support plans of residents #1, #2 and #3 shall be updated to include inappropriate behaviors, as well as a plan to meet the needs of each resident. Copies of the updated support plans for residents #1, #2 and #3 shall be kept in each resident's record. ██ 8/15/22

DIRECTED: Beginning on 8/25/22: A designated staff person shall interview at least 5 residents monthly, in private, to ensure they are free from abuse/neglect, including free from racial slurs. Documentation of the interviews shall be kept, which includes the name of the resident, date and time of the resident interview, the name of the staff person conducting the interview, the questions asked during the interviews, and the resident responses. ██ 8/15/22

DIRECTED: Within 30 calendar days of receipt of the plan of correction: The home will conduct a quality management plan review and evaluation. The Administrator will place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights and Older Adult Protective Services Act (OAPSA) training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and §2600.65(b)(3) and annually in accordance with §2600.65(g)(3) and §2600.65(g)(4).

Completion Date: *08/14/2022*

Not Implemented

82c - Locking Poisonous Materials

1. Requirements

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 approximately 9:30 a.m., numerous poisonous materials with manufacturers' labels indicating, "If swallowed, get

82c - Locking Poisonous Materials (continued)

medical help or contact poison control center" were unlocked and accessible in the electrical storage room outside the kitchen entrance, to include the following:

- *4 gallon bottles of Upper Cut toilet cleaner*
- *2 gallon bottles of G.O.K. Grill and Oven Kleen*
- *2 gallon bottles of Scale Kleen*
- *(9) 17 ounce cans of Glint Stainless Steel Cleaner*

Not all residents of the home, including resident #1, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept***

Immediately, while inspector was on site, all poisionous materials listed (toilet cleaner, grill/oven cleaner, scale kleen amd stainless steel cleaner) was moved to a secure, locked area in the facility.
weekly walk though of the facility by admin or designated person will be done to ensure poisonous materials are in a locked area that is inaccessible to residents. Will keep documentation of weekly walk throughs for 6 months. Walk throughs started 8/1/2022. Staff education conducted on 8/13/2022- topic: 2066.82c locking poisonous materials. documentation of education will be kept.

Completion Date: *08/14/2022*

Not Implemented

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At approximately 9:30 a.m., multiple cigarette butts were present along the sidewalk outside the kitchen exit by the electrical storage room.

At 9:50 a.m., there were 2 used bed pads laying on the floor in the hallway outside resident #4's bedroom door. Also, there was a pile of dirty laundry on the floor at the foot of resident #4 bed. Resident #4's assessment, dated [redacted]/22, indicates resident #4 requires assistance with laundry,

REPEAT VIOLATION: 09/17/2021, et al.; 11/02/2021, et. al.; 02/15/2022, et. al.

Plan of Correction ***Directed***

immediately, while inspector was on site, the area outside the kitchen door was cleaned as well as the hallway and bedroom of resident #4
each day a designated staff person will carefully check the facility for unsanitary conditions. these daily checks will be documented for 6 months. checks and documentation began 8/1/2022. (DIRECTED: The daily checks shall include a daily walkthrough of the entire home, both inside and outside, to ensure sanitary conditions are maintained, and that all residents and staff persons are smoking in the designated smoking areas. Documentation of the daily checks shall be kept. [redacted] 8/15/22).

On 8/13/2022 staff education completed and on 8/14/2022 resident education completed- topic 2600.85.a Sanitary conditions. The education included the location of the designated smoking areas as well as maintaning the sanitary conditions of this location. Documentation of these educations shall be kept.

Not Implemented

85a - Sanitary Conditions (continued)

Completion Date: *08/14/2022*

85e - Trash Outside Home

1. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:55 a.m., no lid was present on the trash can in the home's designated smoking section, which was full of trash. There were also multiple pieces of trash laying on the ground surrounding the uncovered trash can.

REPEAT VIOLATION: 9/17/2021, et. al.

Plan of Correction ***Directed***

immediately, while inspector on site, garbage emptied, lid placed on and garbage in surrounding area cleaned.
Each day a designated staff person will check the designated smoking area to enusure trash outside the home remains covered and that the area is clean and free of garbage. documentaion of daily checks began on 8/1/2022.
(DIRECTED: The daily checks shall include a walkthrough of the entire exterior grounds to ensure all trash outside the home is kept in covered receptacles. Documentation of the daily checks shall be kept. █ 8/15/22).
Staff training on 2600.85e conducted on 8/13/2022- documentation of this training shall be kept.

Completion Date: *08/14/2022* **Not Implemented**

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The double door leading to the home's designated smoking area is in disrepair and will not close completely. Also, there are numerous gaps along the top, bottom and the middle of the door, and numerous cracks in the piece of wood framing, which runs down the center of the double doors for the door latches to secure to.

REPEAT VIOLATION: 09/17/2021, et.al.

Plan of Correction ***Directed***

the double doors leading to the designated smoking area will be replaced within 30 days.
Any other repair needs of floor, wall, ceilings, windows, doors and other surfaces in the future will be done promtly to ensure they are in good repair and free of hazard.
Staff educated on 2600.88a. documentation of education shall be kept.
Weekly checks will be conducted x 6 months and will start the weekof 8/15/2022 by designated staff person to ensure Floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards.

88a - Surfaces (continued)

document. any issues will be reported to administation immediately. (DIRECTED: The weekly checks shall include a walkthrough of the entire home, both inside and outside, to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Documentation of the weekly walkthroughs shall be kept. █ 8/15/22).

Completion Date: *08/14/2022*

Not Implemented

103d - Storing Food Off Floor

1. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

At approximately 9:30 a.m., there were 7 bags of ice stored on the floor of the walk-in freezer, 4 gallons of milk in a milk crate stored on the floor of the walk-in refrigerator, and a 50-pound box of potatoes, approximately 1/4 full, stored on the floor of the food storage room.

Plan of Correction ***Accept***

Immediately, while inspector was on site, the ice, milk and potatoes moved and properly stored off the floor. Dietary staff reeducated on 2600.103d. on 8/1/2022. Documentaion of education shall be kept. see attachment A. Kitchen area will be monitored by designated person three times per week x 1 month, then weekly. documentation will be kept for 6 months. monitoring began 8/1/2022

Completion Date: *08/14/2022*

Not Implemented

125b - Combustible Restrictions

1. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

At approximately 9:30 a.m., there were (9) 17 ounce cans of Glint Stainless Steel Cleaner, with manufacturers' labels indicating, "Danger extremely flammable" unlocked and accessible on the shelf in the electrical storage room, outside the kitchen entrance.

Plan of Correction ***Accept***

Immediately, while inspector was on site, all combustible materials (stainless steel cleaner) was moved to a secure, locked area in the facility.
weekly walk though of the facility by admin or designated person will be done to ensure combustible materials are in a locked area that is inaccessible to residents. Will keep documentation of weekly walk throughs for 6 months. walk throughs/ documentation began 8/1/2022. staff education completed on 8/13/2022 and documentaion of education shall be kept.

Completion Date: *08/14/2022*

Not Implemented

141b1 - Annual Medical Evaluation

1. Requirements

2600.

141b1 - Annual Medical Evaluation *(continued)*

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

Description of Violation

Resident #1's most recent medical evaluation was completed on ███/21.

REPEAT VIOLATION: 09/17/2021, et. al.; 02/15/2022, et. al.

Plan of Correction ***Directed***

Resident 1's annual medical evaluation completed on ██/2022
As part of previous plan of correction, all resident's med evals will be reviewed for completeness and accuracy as well as updates for significant changes by 8/15/2022.
Moving forward a chart has been developed to closely monitor when med evals need to be completed annually. this chart will be updated as needed, (DIRECTED: Beginning on 8/20/22: The audit tool shall be reviewed by a designated person on a monthly basis to ensure all residents have a medical evaluation completed at least annually. Documentation of the audit tool shall be kept, as well as documentation of the monthly reviews of the audit tool shall be kept. Copies of completed medical evaluations shall be kept in each resident's record. ███8/15/22).

DIRECTED: BY 8/30/22: A new medical evaluation shall be completed for resident #1. A copy of the new medical evaluation shall be kept in resident #1's record. ███ 8/15/22

Completion Date: *08/14/2022*

Not Implemented

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1's most recent assessment was completed on ███/21.

REPEAT VIOLATION: 11/02/2021, et. al.; 02/15/2022, et. al.

Plan of Correction ***Directed***

Resident 1's annual assessment completed on ███/2022
As part of previous plan of correction, all resident's assessments will be reviewed for completeness and accuracy as well as updates for significant changes by 8/15/2022.
Moving forward a chart has been developed to closely monitor when assessments need to be completed annually. this chart will be updated as needed. (DIRECTED: Beginning on 8/20/22: The audit tool shall be reviewed by a designated person on a monthly basis to ensure all residents have an assessment completed at least annually. Documentation of the audit tool shall be kept, as well as documentation of the monthly reviews of the audit tool shall be kept. Copies of completed assessments shall be kept in each resident's record. ███ 8/15/22).

Completion Date: *08/14/2022*

Not Implemented