pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: DECEMBER 20, 2022

[redacted]
H and M Personal Care Home, Inc.
[redacted]

RE: H & M Personal Care Home
590 Boggs School Road
Moon Township, Pennsylvania 15108
License/COC #: 448481

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 15, 2022, and September 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 REVOKES your certificate of compliance (license number 428900) dated November 30, 2022 – November 30, 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 December 20, 2022 to June 20, 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	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
121(a)	II	17	$5	$85	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:

[redacted]
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: *H & M PERSONAL CARE HOME* License#: *44848* License Expiration: *11/30/2022*

Address: *590 BOGGS SCHOOL ROAD, MOON TOWNSHIP, PA 15708*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** *724-457-7398* **Email:** [redacted]

Legal Entity

Name: *HAND M PERSONAL CARE HOME INC*

Address: [redacted]

Phone: *7244577398* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date:** *07/25/7983* **Issued By:** *Dept L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *17* **Waking Staff:** *13*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *09/16/2022*

Inspection Dates and Department Representative

09/16/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* **Residents Served:** *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *76* **Are 60 Years of Age or Older:** *13*

Diagnosed with Mental Illness: *76* **Diagnosed with Intellectual Disability:** *7*

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

Inspections/ Reviews

09/16/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/09/2022*

Inspections/ Reviews *(continued)*

10/06/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *7 7/09/2022*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *70/70/2022*

11/08/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *17/09/2022*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *7 7/78/2022*

12/05/2022 - Document Submission

Submitted By: [redacted] **Date Submitted:** *7 7/09/2022*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

1Sa - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701-10225.707) and 6 Pa. Code§ 15.21-15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 6/24/22, there were 77 residents present in the home. Thirteen residents were over the age of 60, *Sixteen residents are diagnosed with mental illness, and one resident is diagnosed with an intellectual disability.*

On 6/24/22, at approximately midnight, staff person A, was the only staff person on duty from 6/24/22 at 9:00 p.m. through 6/25/22 at 9:00 a.m. Staff person A left the home and went to the private residence next door to the home and began consuming alcohol. At approximately 2:30 a.m., police arrived at the private residence because of a fight that occurred between the occupant and staff person B, who also lives in the residence next door to the home. The police department's incident report indicates, "I observed that staff person A was extremely intoxicated. [redacted] *had an odor of alcoholic beverage on her breath, blood shoot (sic}, glassy eyes, slurred speech, and was unsteady on* [redacted] *feet." "Staff person A was impaired and clearly neglecting* [redacted] *responsibilities as the caretaker for the residents of the home." The police administered a Preliminary Breath Test (PBT) on staff person A which resulted in a blood alcohol content of .789%. Seventeen residents were left solely in the care of staff person A, who was intoxicated and absent from the home from approximately midnight on 6/24/22 until 6/25/22 at 3:50 a.m. when staff person B returned to the home to take over* [redacted] *shift. This allegation of abuse was not reported to the local Area Agency on Aging.*

POC Submission ***Directed*** [redacted] ***- 77/08/2022)***

Due to the unforeseen actions of said employee, a report /allegation was not reported to the local area on aging due to police being involved and filing their own report. In the future the administrator knows and understands that such incident MUST be reported due to the severity of the incident the local area on aging as well as the OHS and Older Adult Protective services right away. Upon the administrators knowledge of the said incident the home shall fire said staff member immediately and cover the shift appropriately and comply with the homes and the states policy for actions to take with the said employee as well as the pink book 2600. policy of abuse reported covered by law. In result of the said incident the home administrator will be held to instruct employees on 2600. 75.Abuse reported by law. A phone call was made to the allegheny area on aging to make an appointment for them to come out and do their own training. a training record can be provided if necessary after the training is completed. attached is the administrators training that was done immediately after the incident. written report also provided

DIRECTED

Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall audit all allegations of abuse daily to ensure all allegations of abuse are reported in accordance with Regulation 2600. 75(a). 77/8/22 [redacted]

Licensee's Proposed Overall Completion Date 11/10/22 ***Not Implemented (*** [redacted] ***- 12/05/2022)***

1Sd - Resident Abuse-Notification

2. Requirements

2600.

15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

1Sd - Resident Abuse-Notification *(continued)*

Description of Violation

On 6/24/22, there were 77 residents present in the home. Thirteen residents were over the age of 60, Sixteen residents are diagnosed with mental illness, and one resident is diagnosed with an intellectual disability.

*On 6/24/22, at approximately midnight, staff person **A,** was the only staff person on duty from 6/24/22 at 9:00 p.m. through 6/25/22 at 9:00 a.m. Staff person A left the home and went to the private residence next door to the home and began consuming alcohol. At approximately 2:30 a.m., police arrived at the private residence because of a fight that occurred between the occupant and staff person B, who also lives in the residence next door to the home. The police department's incident report indicates, "I observed that staff person A was extremely intoxicated. [redacted] had an odor of alcoholic beverage on [redacted] breath, blood shoot (sic), glassy eyes, slurred speech, and was unsteady on her feet." "Staff person A was impaired and clearly neglecting [redacted] responsibilities as the caretaker for the residents of the home." The police administered a Preliminary Breath Test (PBT) on staff person **A** which resulted in a blood alcohol content of .789%. Seventeen residents were left solely in the care of staff person A, who was intoxicated and absent from the home from approximately midnight on 6/24/22 until 6/25/22 at 3:50 a.m. when staff person B returned to the home to take over [redacted] shift. The residents and their designated persons were not notified of this allegation of abuse.*

POC Submission ***Directed ([redacted] - 11/08/2022)***

After the incident that occurred on 6/24/2022 involving a former staff member leaving the residents to go next door and consume alcohol. All residents and family members were made aware of the incident that occurred on 06/24/2022 involving former employee. Signature sheet attached. Everyone in the home and family members know what happened and that [redacted] was fired immediately and is not permitted on the premises. all residents were taken care of and no-one one hurt before another supervisor arrived at the scene. She went inside the PCH and checked all rooms to observe if any residents have been harmed in anyway and no-one was. The rest of the former employees shift was covered and the residents were attended to for the rest of the night into the next morning before a relief staff member came in. Residents were not left alone at anytime after.

DIRECTED
Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall audit all allegations of abuse daily to ensure all allegations of abuse are reported in accordance with Regulation 2600.75(d). 77/8/22[redacted]

Licensee's Proposed Overall Completion Date 11/10/22 ***Not Implemented ([redacted] - 12/05/2022)***

16c - Written Incident Report

3. 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 6/24/22, there were 77 residents present in the home. Thirteen residents were over the age of 60, Sixteen residents are diagnosed with mental illness, and one resident is diagnosed with an intellectual disability.

On 6/24/22, at approximately midnight, staff person A, was the only staff person on duty from 6/24/22 at 9:00 p.m. through 6/25/22 at 9:00 a.m. Staff person A left the home and went to the private residence next door to the home and began consuming alcohol. At approximately 2:30 a.m., police arrived at the private residence because of a fight that

76c - Written Incident Report (continued)

occurred between the occupant and staff person B, who also lives in the residence next door to the home. The police department's incident report indicates, "I observed that staff person A was extremely intoxicated. [redacted] had an odor of alcoholic beverage on her breath, blood shoot (sic}, glassy eyes, slurred speech, and was unsteady on her feet." "Staff person A was impaired and clearly neglecting [redacted] responsibilities as the caretaker for the residents of the home." The police administered a Preliminary Breath Test (PBT) on staff person A which resulted in a blood alcohol content of .789%. Seventeen residents were left solely in the care of staff person A, who was intoxicated and absent from the home from approximately midnight on 6/24/22 until 6/25/22 at 3:50 a.m. when staff person B returned to the home to take over [redacted] shift. This incident was not reported to the Department.

POC Submission ***Directed ([redacted] - 77/08/2022)***

After the incident that occurred on June 24, 2022 with staff person A there was no incident report reported due to the fact that I thought the police were handling there own report, there fore after I had gotten the report I knew I needed to report this on my own to the area on aging and write out my own incident report which has been done. this type of incident will nt happen again, although I am not in the PCH 24/7 I implemented a system where I call every shift to make sure there is a person on duty and surprise calls and visits. if such incident or any incident as such will be reported immediately.

DIRECTED
Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall audit all reportable incidents and conditions daily to ensure all reportable incidents and conditions are reported in accordance with Regulation 2600.76(c). 7 7/8/22 [redacted]

Within 75 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements on Regulation 2600.76(c). Documentation of education shall be kept. 7 7/8/22 [redacted]

Licensee's Proposed Overall Completion Date 11/23/22 ***Not Implemented ([redacted] - 12/05/2022)***

42b - Abuse

4. 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 6/24/22, there were 77 residents present in the home. Thirteen residents were over the age of 60, *Sixteen residents are diagnosed with mental illness, and one resident is diagnosed with an intellectual disability.*

On 6/24/22, at approximately midnight, staff person A, was the only staff person on duty from 6/24/22 at 9:00 p.m. through 6/25/22 at 9:00 a.m. Staff person A left the home and went to the private residence next door to the home and began consuming alcohol. At approximately 2:30 a.m., police arrived at the private residence because of a fight that occurred between the occupant and staff person B, who also lives in the residence next door to the home. The police department's incident report indicates, "I observed that staff person A was extremely intoxicated.[redacted] had an odor of alcoholic beverage on her breath, blood shoot (sic}, glassy eyes, slurred speech, and was unsteady on [redacted] feet." "Staff person A was impaired and clearly neglecting [redacted] responsibilities as the caretaker for the residents of the home." The police administered a Preliminary Breath Test (PBT) on staff person A which resulted in a blood alcohol content of .789%. Seventeen residents were left solely in the care of staff person A, who was intoxicated and absent from the

42b - Abuse (continued)

home from approximately midnight on 6/24/22 until 6/25/22 at 3:50 a.m. when staff person B returned to the home to take over [redacted] shift.

POC Submission ***Directed ([redacted] 11/08/2022)***

A staff meeting was held where we discussed the incident above and how to handle these situations along with education on abuse to the employees by the home administrator. After the incident that occurred on June 24, 2022 with staff person A there was no incident report reported due to the fact that I thought the police were handling there own report, there fore after I had gotten the report I knew I needed to report this on my own to the area on aging and write out my own incident report which has been done. this type of incident will nt happen again, although I am not in the PCH 24/7 I implemented a system where I call every shift to make sure there is a person on duty and surprise calls and visits. if such incident or any incident as such will be reported immediately. a call has been put in to the area on aging for them to come out and conduct there own training at which time I find out the date I will let [redacted] know immediately along with a sign in sheet for a staff training.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall initiate a procedure to privately interview at least two residents a week to ensure residents are not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. Documentation of interviews shall be kept. 7 7/8/22 [redacted]

Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall contact the Area Agency on Aging and schedule an all staff training on abuse prevention and reporting. Documentation of training shall be kept. 77/8/22 [redacted]

Licensee's Proposed Overall Completion Date 11/13/22 ***Not Implemented ([redacted] - 12/05/2022)***

57a - Designee Present/Age

5. Requirements

2600.
57.a. At all times one or more residents are present in the home a direct care staff person who is 21 years of age or older and who serves as the designee, shall be present in the home. The direct care staff person may be the administrator if the administrator provides direct care services.

Description of Violation

On 6/24/22, there were 7 7 residents present in the home. Thirteen residents were over the age of 60, Sixteen residents are diagnosed with mental illness, and one resident is diagnosed with an intellectual disability.

On 6/24/22, at approximately midnight, staff person A, was the only staff person on duty from 6/24/22 at 9:00 p.m. through 6/25/22 at 9:00 a.m. Staff person A left the home and went to the private residence next door to the home and began consuming alcohol. At approximately 2:30 a.m., police arrived at the private residence because of a fight that occurred between the occupant and staff person B, who also lives in the residence next door to the home. The police department's incident report indicates, "I observed that staff person A was extremely intoxicated. [redacted] had an odor of alcoholic beverage on [redacted] breath, blood shoot (sic}, glassy eyes, slurred speech, and was unsteady on [redacted] feet." "Staff person A was impaired and clearly neglecting [redacted] responsibilities as the caretaker for the residents of the home." The police administered a Preliminary Breath Test (PBT) on staff person A which resulted in a blood alcohol content of

57a - Oesignee Present/Age (continued)

.789%. Seventeen residents were left solely in the care of staff person A, who was intoxicated and absent from the home from approximately midnight on 6/24/22 until 6/25/22 at 3:50 a.m. when staff person 8 returned to the home to take over [redacted] shift.

POC Submission ***Directed ([redacted] - 77/08/2022)***

Due to this unforeseen incident at the Personal Care Home the administrator has conducted a staff meeting where the incident was discussed and 2600.570 was discussed. A staff meeting was held where we discussed the incident above and how to handle these situations along with education on abuse to the employees by the home administrator. After the incident that occurred on June 24, 2022 with staff person A there was no incident report reported due to the fact that I thought the police were handling there own report, there fore after I had gotten the report I knew I needed to report this on my own to the area on aging and write out my own incident report which has been done. this type of incident will nt happen again, although I am not in the PCH 24/7 I implemented a system where I call every shift to make sure there is a person on duty and surprise calls and visits. if such incident or any incident as such will be reported immediately. a call has been put in to the area on aging for them to come out and conduct there own training at which time I find out the date I will let [redacted] know immediately along with a sign in sheet for training. at all times there will be a staff person on duty who is 21 years of age or older.

DIRECTED
Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall develop and implement a scheduling process to ensure compliance with Regulation 2600.57(0). 7/8/22 [redacted]

Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall audit he past weeks schedule on a weekly basis to ensure compliance with Regulation 2600.57(0) was met. 7/8/22 [redacted]

Licensee's Proposed Overall Completion Date 11/10/22 ***Not Implemented ([redacted] - 12/05/2022)***

63a - First Aid/CPR Training

6. 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 6/24/22, there were 77 residents present in the home. Thirteen residents were over the age of 60, Sixteen residents are diagnosed with mental illness, and one resident is diagnosed with an intellectual disability.

On 6/24/22, at approximately midnight, staff person A, was the only staff person on duty from 6/24/22 at 9:00 p.m. through 6/25/22 at 9:00 a.m. Staff person A left the home and went to the private residence next door to the home and began consuming alcohol. At approximately 2:30 a.m., police arrived at the private residence because of a fight that occurred between the occupant and staff person 8, who also lives in the residence next door to the home. The police department's incident report indicates, "I observed that staff person A was extremely intoxicated. [redacted] had an odor of alcoholic beverage on [redacted] breath, blood shoot (sic), glassy eyes, slurred speech, and was unsteady on [redacted] feet." "Staff person A was impaired and clearly neglecting [redacted] responsibilities as the caretaker for the residents of the home." The police administered a Preliminary Breath Test (PBT) on staff person A which resulted in a blood alcohol content of .789%. Seventeen residents were left solely in the care of staff person A, who was intoxicated and absent from the home from approximately midnight on 6/24/22 until 6/25/22 at 3:50 a.m. when staff person 8 returned to the home to take

63a - First Aid/CPR Training (continued)

over [redacted] shift. During this time there were no staff persons present in the home who are trained in first aid and certified in obstructed airway techniques and CPR.

POC Submission ***Directed [redacted] - 11/08/2022)***

See attached. at the time of said incident all the home administrators employees were CPR qualified. A staff meeting was held where we discussed the incident above and how to handle these situations along with education on abuse to the employees by the home administrator. After the incident that occurred on June 24, 2022 with staff person A there was no incident report reported due to the fact that I thought the police were handling there own report, there fore after I had gotten the report I knew I needed to report this on my own to the area on aging and write out my own incident report which has been done. this type of incident will nt happen again, although I am not in the PCH 24/7 I implemented a system where I call every shift to make sure there is a person on duty and surprise calls and visits. if such incident or any incident as such will be reported immediately. a call has been put in to the area on aging for them to come out and conduct there own training at which time I find out the date I will let [redacted] know immediately along with a sign in sheet for a staff training. at all times there will be a staff person on duty that is CPR trained and 27 years of age or older.

DIRECTED
Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall develop and implement a scheduling process to ensure compliance with Regulation 2600.63(0). 7 7/8/22[redacted]

Within 2 calendar days of receipt of the accepted plan of correction: The administrator shall audit he past weeks schedule on a weekly basis to ensure compliance with Regulation 2600.63(0) was met. 7 7/8/22[redacted]

Licensee's Proposed Overall Completion Date 11/10/11 ***Not Implemented [redacted] - 12/05/2022)***