

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

December 6, 2022

[REDACTED]
ROSE OF SHARON HOME INC
PO BOX 336, 135 MAIN STREET
SAINT MICHAEL, PA, 15951

RE: ROSE OF SHARON HOME, INC.
135 MAIN STREET, PO BOX 336
SAINT MICHAEL, PA, 15951
LICENSE/COC#: 33206

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/28/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

| Facility Information | | |
|--|-------------------------|---------------------------------------|
| Name: ROSE OF SHARON HOME, INC | License #: 33206 | License Expiration: 07/10/2023 |
| Address: 135 MAIN STREET, PO BOX 336, SAINT MICHAEL, PA 15951 | | |
| County: CAMBRIA | Region: CENTRAL | |

| Administrator | | |
|-------------------------|--------------------------|--------------------------|
| Name: [REDACTED] | Phone: [REDACTED] | Email: [REDACTED] |

| Legal Entity | | |
|---|--------------------------|--|
| Name: ROSE OF SHARON HOME INC | | |
| Address: PO BOX 336, 135 MAIN STREET, SAINT MICHAEL, PA, 15951 | | |
| Phone: [REDACTED] | Email: [REDACTED] | |

| Certificate(s) of Occupancy | | |
|-----------------------------|-------------------------|-------------------------|
| Type: C 2 LP | Date: 12/27/1993 | Issued By: D L&I |

| Staffing Hours | | |
|----------------------------------|------------------------------|-------------------------|
| Resident Support Staff: 0 | Total Daily Staff: 15 | Waking Staff: 11 |

| Inspection Information | | |
|-----------------------------------|----------------------------|---|
| Type: Full | Notice: Unannounced | BHA Docket #: |
| Reason: Renewal, Complaint | | Exit Conference Date: 09/28/2022 |

| Inspection Dates and Department Representative | |
|--|--------------------|
| 09/28/2022 | On Site [REDACTED] |

| Resident Demographic Data as of Inspection Dates | | | |
|--|--------------|--|--------------------------|
| General Information | | | |
| License Capacity: 30 | | Residents Served: 15 | |
| Secured Dementia Care Unit | | | |
| In Home: No | Area: | Capacity: | Residents Served: |
| Hospice | | | |
| Current Residents: 0 | | | |
| Number of Residents Who: | | | |
| Receive Supplemental Security Income: 4 | | Are 60 Years of Age or Older: 15 | |
| Diagnosed with Mental Illness: 0 | | Diagnosed with Intellectual Disability: 0 | |
| Have Mobility Need: 0 | | Have Physical Disability: 0 | |

| Inspections / Reviews | | |
|-----------------------------------|---------------------------------------|-----------------------------------|
| 09/28/2022 - Full | | |
| Lead Inspector: [REDACTED] | Follow-Up Type: POC Submission | Follow-Up Date: 10/24/2022 |
| 11/09/2022 - POC Submission | | |
| Submitted By: [REDACTED] | Date Submitted: 12/06/2022 | |
| Reviewer: [REDACTED] | Follow-Up Type: POC Submission | Follow-Up Date: 11/17/2022 |

Inspections / Reviews (*continued*)

11/17/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/06/2022

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 12/02/2022

12/06/2022 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/06/2022

Reviewer: [REDACTED]

Follow-Up Type: Not Required

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 9/28/22 at approximately 10:40 AM, the battery-operated carbon monoxide alarm in the living room was observed with a label, dated 3/2/2021. However, per the Care Facility Carbon Monoxide Alarm Standards Act, the battery is to be changed at least once annually.

POC Submission

Accept ([redacted] - 11/09/2022)

Administrator changed the battery by 11:30 am on 9 28 22. Administrator made an entry into [redacted] calendar app to remind [redacted] to change the battery again within 6 months (3 28 23). Administrator will continue to make an entry in [redacted] calendar app to change the battery every 6 months. Please see attached.

Licensee's Plan Completion Date: 10/14/2022

Implemented [redacted] - 12/06/2022)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Person A was initially hired on [redacted] 15 and a criminal background check was completed at that time. [redacted] year break in employment, Staff Person A was rehired on [redacted] 2020 and a criminal background check was not obtained.

Plan of Correction

Accept [redacted] - 11/17/2022)

Staff Person A was rehired during the pandemic ([redacted]/2020). This Administrator greatly appreciates your understanding that this requirement was not completed at that time. Staff Person A has worked for us for numerous years [redacted]. Staff Person A is also extremely well known to this Administrator. [redacted]

[redacted] However, the Administrator understands the importance of this requirement and has submitted a Background Check request. Please see attached.

The Criminal Background Check was completed again on [redacted] 22 and returned with no record. An audit of all current staff will be done by 11 21 22 to ensure criminal checks are completed. Please see attached new hire checklist which the Administrator will use to ensure continued compliance. This checklist was implemented 11 16 22. New hires will be addressed at the next Quality Management review on 12 07 22.

51 - Criminal Background Check (continued)

Licensee's Proposed Overall Completion Date: 12/07/2022

Implemented [redacted] - 12/06/2022)

65a FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person A, who was rehired on [redacted]/2020 [redacted], never completed orientation on the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction

Accept [redacted] 11/17/2022)

Administrator re-educated Staff Person A on all items listed on 10-18-22. Please see attached for details.

Administrator will complete an audit of all current staff to ensure all trainings are completed. This audit will be done by 11-21-22. The Administrator will use the attached New Hire Checklist to ensure training requirements are met. This checklist was implemented on 11-16-22. New hire and training needs will be addressed at the next Quality Management review on 12-7-22.

Licensee's Proposed Overall Completion Date: 12/07/2022

Implemented [redacted] 12/06/2022)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.

65b - Rights/Abuse 40 Hours (continued)

2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person A, who was rehired on 11/1/2020 [REDACTED] never completed training in the following topics:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Plan of Correction

Accept ([REDACTED] - 11/17/2022)

Administrator re-educated Staff Person A on all items listed on 10-18-22. Please see attached for details.

Administrator will complete an audit of all current staff to ensure all trainings are completed. This audit will be completed by 11-21-22. Administrator will use the attached New Hire Checklist to ensure requirements are met. This checklist was implemented on 11-16-22. New hires and training needs will be addressed at the next Quality Management review on 12-7-22.

Licensee's Proposed Overall Completion Date: 12/07/2022

Implemented ([REDACTED] - 12/06/2022)

65d - Initial Direct Care Training**5. Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs
 - iii. Personal hygiene.
 - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
 - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - vi. Implementation of the initial assessment, annual assessment and support plan.
 - vii. Nutrition, food handling and sanitation.
 - viii. Recreation, socialization, community resources, social services and activities in the community.
 - ix. Gerontology.
 - x. Staff person supervision, if applicable.
 - xi. Care and needs of residents with special emphasis on the residents being served in the home.
 - xii. Safety management and hazard prevention.
 - xiii. Universal precautions.
 - xiv. The requirements of this chapter.
 - xv. Infection control.
 - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

65d - Initial Direct Care Training (*continued*)**Description of Violation**

Direct Care Staff Person A, who was re-hired on [REDACTED] 2020 [REDACTED], began providing unsupervised ADL services, however, initial direct care staff person training to include the following was not provided:

- i. Safe management techniques.
- ii. ADLs and IADLs
- iii. Personal hygiene.
- iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
- v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
- vi. Implementation of the initial assessment, annual assessment and support plan.
- vii. Nutrition, food handling and sanitation.
- viii. Recreation, socialization, community resources, social services and activities in the community.
- ix. Gerontology.
- x. Staff person supervision, if applicable.
- xi. Care and needs of residents with special emphasis on the residents being served in the home.
- xii. Safety management and hazard prevention.
- xiii. Universal precautions.
- xiv. The requirements of this chapter.
- xv. Infection control.
- xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Plan of Correction

Accept ([REDACTED] - 11/17/2022)

Administrator re-educated Staff Person A on all items listed on 10-18-22. Please see attached for details. Staff Person A completed and passed the online testing for Direct Care Workers on 10-18-22.

Administrator will complete an audit of all current staff to ensure all trainings are completed. This audit will be completed by 11-21-22. Administrator will use the attached New Hire Checklist to ensure requirements are met. This checklist was implemented on 11-16-22. New hires and training needs will be addressed at the next Quality Management review on 12-7-22.

Licensee's Proposed Overall Completion Date: 12/07/2022

Implemented ([REDACTED] - 12/06/2022)

83a - Indoor Temperature

6. Requirements

2600.

83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

On 9/28/2022 at 2:55 PM, Bedroom [REDACTED] indoor temperature was 64 degrees Fahrenheit despite the thermostat being

83a - Indoor Temperature (continued)

set at 72 degrees. At 3:50 PM, the bedroom's indoor temperature was 66 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 11/17/2022)

When it was discovered that the thermostat in Bedroom [redacted] was below 70 degrees, a furnace repair man was contacted. He repaired the malfunction by 4:30 pm on 9-28-22. There was no other issue regarding the heating system. All other areas of the Home were functioning properly and remain so. Administrator certifies that the problem has been corrected. Administrator has monitored the thermostat in Bedroom [redacted] as well as the other thermostats in the Home. All areas are heating properly. Please see attached.

Administrator will complete an audit of resident areas to check for proper temperatures beginning 10-4-22 and continuing weekly until 12-7-22. Resident [redacted] room will be checked weekly beginning 10-4-22 and continuing weekly until 12-7-22. Administrator and the Team Members assigned to maintenance issues will complete a check for any issues which need addressed, particularly when the heating is turned on in the fall. This check began on 10-4-22.

Licensee's Proposed Overall Completion Date: 12/07/2022

Implemented ([redacted] - 12/06/2022)

85d - Trash Receptacles

7. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 9/28/22 at approximately 10:20 AM, both shower rooms were observed with uncovered, unattended trash cans.

Plan of Correction

Accept [redacted] 11/17/2022)

Please note that it has been our practice to use a very small trash can in the shower rooms for soiled incontinence products. After each shower, this can is emptied. This practice has served us well and all employees consistently empty the can after each shower. There was no trash in either can on the date of the Inspection. Both cans were empty and clean. However, the Administrator understands the requirement and purchased new trash cans for the shower rooms with lids on 10-14-22. Please see attached.

Staff were re-educated on this regulation at our staff meeting on 10-19-22. Please see attached.

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented ([redacted] 12/06/2022)

93a - Handrails

8. Requirements

93a - Handrails (continued)

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 9/28/2022 at approximately 10:40 AM, the right-handed descending handrail, leading into the living room, was loose and wobbly.

Plan of Correction

Accept () - 11/17/2022

Upon closer inspection of the loose handrail leading into the living room, it was discovered that there was a crack in the base of the handrail post. The handrail post was entirely replaced on 10 3 22. The Administrator certifies that this corrected the problem and the handrail is sturdy once again. Please see attached.

Administrator and the Team Member currently assigned to maintenance safety issues will complete a check of maintenance safety issues on a monthly basis, for example handrails. Any issues discovered will be corrected in a timely fashion. Implementation of this will begin 11 16 22.

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented () - 12/06/2022

101j4 - Bedroom Storage Area

9. Requirements

2600.

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

- 4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

Description of Violation

Resident #1 has a chest of drawers, but does not have access to a closet or wardrobe with clothing racks or shelves in the bedroom.

Plan of Correction

Accept () - 11/17/2022

Resident #1's armoire was in an adjacent room. Staff moved Resident #1's armoire into her bedroom on 10 17 22. Please see attached.

Staff were re educated on this regulation at our staff meeting on 10 19 22. Please see attached.

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented () - 12/06/2022

102i - Soap Dispenser

10. 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

There was an unlabeled, used bar of soap observed in each of the shared bathrooms by Room (), by Room () and by Rooms () and ().

102i - Soap Dispenser (continued)

Plan of Correction

Accept (████) 11/17/2022

One of the bathrooms mentioned in this requirement, is a private bathroom. It is not shared by another resident. However, Administrator did label this private bathroom's soap dish on 9-28-22. Administrator marked the soap dishes for each of the residents who share these bathrooms on 9-28-22. Please note that each of the residents involved in this requirement are completely cognitively aware of which bar of soap is theirs. They would not use another person's soap. Staff were re-educated on this requirement 10-19-22. Please see attached.

Shared bathrooms will be checked for unlabeled bars of soap by the nightshift Caregiver on a weekly basis starting 11-16-22 for the next month, through 12-16-22. Administrator has been checking regularly and this regulation continues to be in compliance.

Licensee's Proposed Overall Completion Date: 12/16/2022

Implemented (████) - 12/06/2022

125b - Combustible Restrictions

11. Requirements

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

Description of Violation

On 9/28/2022 at approximately 10:40 AM, a propane tank was unlocked, unattended and accessible to residents in the gas grill on the back deck.

Plan of Correction

Accept (████) 11/17/2022

Administrator added a chain lock to the gas grill on the back deck on 10-17-22. Administrator certifies that this grill will remain locked and inaccessible to residents when not in direct supervised use. Please see attached.

Staff were re-educated on this regulation at our staff meeting on 10-19-22. Please see attached.

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented (████) - 12/06/2022

183b - Meds and Syringes Locked

12. Requirements

- 2600.
- 183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident s room.

Description of Violation

On █████ 2022 at approximately █████ PM, █████ was unlocked and accessible on Resident #2's dresser █████.

183b - Meds and Syringes Locked (continued)

Plan of Correction

Accept ([redacted]) 11/17/2022)

Administrator removed the [redacted] from Resident #2's bedroom on 9-28-22. Administrator discussed at length with Resident #2 the reason for the regulation and how important it is for all medications to be locked. Resident #2 states that [redacted] understands the regulation and has agreed to comply. Administrator certifies that if any resident is deemed able to self-administer medications that those medications will be kept locked and inaccessible to other residents. Staff will also be re-educated on compliance with this regulation at our staff meeting 10-19-22. Please see attached.

Administrator will complete an audit of all resident rooms to ensure medications are not being kept in unlocked rooms. This will be completed by 11-28-22. All residents will be reminded that they are not able to keep medications, including over the counter, in their unlocked rooms. This will be completed by 11-28-22. Resident #2's room will be checked weekly for the next 2 months beginning 11-16-22 through 1-16-23 to ensure that no unlocked medications are present. This will be done by the Administrator.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 12/06/2022)

185a - Implement Storage Procedures

13. 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 #2's glucometer was not calibrated to the current date. The current date was 9/28/22 and the Freestyle Lite glucometer indicated that it was 7/29/22.

For Resident #3, [redacted] and [redacted] were not available in the home.

For Resident #3, the glucometer readings do not match the Medication Administration Record (MAR):

| Glucometer | MAR |
|----------------------------|------------------------------|
| 9/25 6:55 am - [redacted] | 9/25 7:30 am - [redacted] |
| 9/23 4:22 pm - [redacted] | no reading marked in the MAR |
| 9/23 11:03 am - [redacted] | 9/23 11:30 am - [redacted] |
| 9/21 11:01 am - [redacted] | 9/21 11:30 am - [redacted] |

Plan of Correction

Accept ([redacted]) - 11/17/2022)

Residents #2's glucometer was calibrated by the Administrator on 9-29-22. Please see attached. Staff will be re-educated on this requirement at our meeting on 10-19-22. Please see attached.

Resident #3's [redacted] were received by our Pharmacy on 9-29-22. Please see attached. Staff will be

185a - Implement Storage Procedures (continued)

re-educated on this requirement at our meeting on 10-19-22. Please see attached.

Administrator verified the glucometer readings on Resident #3's glucometer with the Medication Administration Record (MAR) on 10-17-22 for the period from 9-28-22 through 10-17-22. The readings on Resident #3's glucometer matches the MAR. Staff will be re-educated on this requirement at our meeting on 10-19-22. Please see attached.

Administrator completed an audit of all glucometers on 9-29-22 and 11-16-22. All were properly calibrated. Administrator developed a log to check all glucometers on a monthly basis. The log was implemented on 11-16-22 and the night shift caregiver will be responsible for checking the glucometers monthly.

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented (█ - 12/06/2022)