

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

December 23, 2022

[REDACTED], ADMINISTRATOR
MAYBROOK-C EVERGREEN OPCO LLC
[REDACTED]

RE: THE GROVE AT HARMONY
191 EVERGREEN MILL ROAD
HARMONY, PA, 16037
LICENSE/COC#: 44757

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/11/2022, 10/12/2022, 10/13/2022 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: *THE GROVE AT HARMONY* License #: *44757* License Expiration: *02/15/2023*
 Address: *191 EVERGREEN MILL ROAD, HARMONY, PA 16037*
 County: *BUTLER* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *MAYBROOK-C EVERGREEN OPCO LLC*
 Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/16/1988* Issued By: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *5* Waking Staff: *4*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *10/13/2022*

Inspection Dates and Department Representative

10/11/2022 - On-Site [REDACTED]
 10/12/2022 - On-Site [REDACTED]
 10/13/2022 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *44* Residents Served: *5*
 Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:
 Hospice
 Current Residents: *0*
 Number of Residents Who:
 Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *5*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

10/11/2022 Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/18/2022*

Inspections / Reviews (*continued*)

11/22/2022 POC Submission

Submitted By: [REDACTED] Date Submitted: 12/22/2022
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 11/30/2022

12/05/2022 POC Submission

Submitted By: [REDACTED] Date Submitted: 12/22/2022
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 12/22/2022

12/23/2022 Document Submission

Submitted By: [REDACTED] Date Submitted: 12/22/2022
Reviewer: [REDACTED] Follow Up Type: Not Required

20b1 - Financial Records

1. Requirements

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

On [REDACTED] resident #1, did not have a cash distribution sheet being used to monitor cash transactions. According to the 3"x 2" scrap paper and varied receipts, the resident should have a balance of [REDACTED]; however, the residents cash funds available were [REDACTED]

On [REDACTED], resident #2's cash distribution sheet indicates a balance of [REDACTED]; however, these funds were distributed to the resident and not indicated appropriately on the cash distribution sheet. An additional [REDACTED] in cash were in envelopes labeled for resident #2; however, these cash funds were not indicated on the cash distribution sheet.

Plan of Correction

Accept [REDACTED] - 12/02/2022)

On 10/12/22, Administrator replaced record of financial transactions, cash distribution record, and quarterly financial quarterly financial summary. On 10/12/22, Administrator replaced [REDACTED] was replaced in Resident #2's accounting deficit. MT/CNAs have been provided verbal education and reeducation in process and procedure with confirmed understanding on 10/14/22. Funds Management is now also subject to Quarterly Audit Review as of 10/14/22 with Administrator and Business Office Manager.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

25a - Written Contract and Review

2. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

On 10/12/22, resident #3 was admitted to the home on [REDACTED] However, upon inspection the contract did not indicate a month, day, or year that the contract will take effect.

Plan of Correction

Accept [REDACTED] - 12/05/2022)

On 10/14/22, The Admissions Contract for Resident #3 was amended by Administrator to reflect original admission date of [REDACTED] in conjunction with resident and Designated POA. Starting 10/14/22 after initial review, Administrator will review quarterly to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

25b - Contract Signatures

3. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

On 10/12/22, the undated contract for resident #3, was not signed by the resident nor does it indicate the resident's inability to sign.

Plan of Correction

Accept ([redacted] - 12/05/2022)

On 10/14/22, The Admissions Contract for Resident #3 was amended by Administrator to reflect original admission date of [redacted] in conjunction with resident and Designated POA, and a notation reflecting Resident #3's near total vision impairment and confirmed verbal understanding. Starting 10/14/22 after initial review, Administrator will review quarterly thereafter to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([redacted] - 12/23/2022)

26a Quality Management Plan

4. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

On 12/12/22 the home had not conducted a quality management review within the last year.

Plan of Correction

Accept ([redacted] - 12/05/2022)

On 10/14/22, Administrator in conjunction with Quality Management Policy, and Quality Management Review form were implemented alongside with a quarterly audit starting 10/14/22.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([redacted] - 12/23/2022)

51 Criminal Background Check

5. 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

Direct care staff person A was hired [redacted]; however, on [redacted] a criminal background check had not been completed by the home.

Plan of Correction

Accept ([redacted] - 12/05/2022)

On [redacted], Administrator and Human Resources Department, the criminal background check for Staff Person A was located and placed in Staff Person A's employee file. Starting [redacted], Administrator will review quarterly to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([redacted] - 12/23/2022)

54a - Direct Care Staff

6. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

On 10/11/22, it was determined that direct care staff person B, hired [REDACTED], did not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept ([REDACTED]) - 12/05/2022)

On 10/14/22, Administrator and Human Resources Director located the high school diploma for Staff Person B and the high school diploma was placed in Staff Person B's employee file. Following Administrator's initial review on 10/14/22 Administrator will conduct quarterly audits will occur thereafter to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([REDACTED]) - 12/23/2022)

65d - Initial Direct Care Training

7. Requirements

2600.

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

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
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.

Description of Violation

On 10/11/22 it was determined that direct care staff person B, while hired [REDACTED] had not successfully completed the approved direct care training course or passed the competency test; however, this staff person began providing

65d - Initial Direct Care Training (continued)

unsupervised ADL services on [REDACTED].

Plan of Correction

Accept [REDACTED] - 12/05/2022)

As of 9/10/22, Administrator and Human Resources Director dated Staff Person B to no longer be with the company and despite attempts have been unable to procure documentation.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

88a - Surfaces**8. 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

On 10/11/22, it was observed that the left corner of the ceiling in the single use common bathroom, next to bedroom #14, was sagging approximately 3" and had discolored brownish area measuring approximately 18" x 18".

Plan of Correction

Accept [REDACTED] - 12/05/2022)

On 10/16/22, Administrator and Maintenance Department began active repairs to the left corner ceiling in single use common bathroom. On 10/14/22, Administrator implemented a form, and completed initial review to track Structural/Cosmetic Survey rounds and this is subject to quarterly review as of 10/14/22 with Maintenance Department and Administrator. On 11/21/22, Maintenance Department and Administrator verbally confirmed restoration totality and the bathroom was opened for communal use.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

94a - Interior/Exterior Doors**9. Requirements**

2600.

94.a. Interior and exterior doors that open directly into a stairway and are used for exit doors, resident areas and fire exits must have a landing, which is a minimum of 3 feet by 3 feet.

Description of Violation

On 10/11/22, it was observed that the top metal step, below the second landing in the emergency exit stairwell, accessible from bedroom 11 on the first floor and the basement, was broken in half and not attached to the internal fire escape staircase, thereby posing a hazard.

Plan of Correction

Accept [REDACTED] - 12/05/2022)

On 10/12/22, Administrator and Maintenance Department repaired the top metal step. On 10/16/22, Maintenance Director and Administrator established an Audit Form and physical site inspection to review and occur quarterly from the date of 10/16/22. Starting 10/14/22, Administrator and Maintenance Director will review quarterly to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

131f Fire Extinguisher Inspection

10. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 10/11/22, all observed fire extinguisher inside the home, including the following, had not been inspected since September 2021:

Two fire extinguishers located near both emergency exit doors on the 1st floor, 2nd floor, and 3rd floor

A Silver, K class, extinguisher located in the kitchen

Repeat violation: 9/29/21

Plan of Correction

Accept ([redacted]) - 12/05/2022)

On 10/31/22, Administrator, Maintenance Director completed a physical site walk through and completed evaluation and work acknowledgement for an annual fire extinguisher inspection and renewal with [redacted] vendor. On 10/16/22, a Survey Fire Extinguisher Audit form was implemented on a quarterly basis from the date of 10/31/22 with Administration and Maintenance Director.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([redacted]) - 12/23/2022)

132a Monthly Fire Drill

11. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

On 10/12/22, it was observed that a monthly unannounced fire drill had not been conducted in September 2022.

Plan of Correction

Accept ([redacted]) - 12/05/2022)

On 10/14/22, Administrator and Maintenance Department established a monthly fire drill schedule through the end of calendar year 2023. Starting 10/14/22, Administrator will review quarterly to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([redacted]) - 12/23/2022)

132c Fire Drill Records

12. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

132c Fire Drill Records (continued)

Description of Violation

On 10/12/22, the fire drill record indicated that a fire drill was conducted on 6/24/22; however, the time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative sections are all blank.

On 10/12/22, the home was licensed for 44 residents. The fire drill records, for the following, exceeded the fire safe evacuation time of 4 minutes zero seconds, established by the fire safety expert, does not contain an accurate number of staff nor resident participating, the number of residents in the home at the time of the drill exceeded the licensing capacity. Additionally, the exit routes and the amount of time it took for evacuation were not recorded on the homes form:

<i>Date & time</i>	<i>Time of all clear</i>	<i>The number of residents in the home at time of the drill</i>	<i>The number of residents evacuated</i>	<i>The number of staff persons participating</i>
6/28/22 1:30 p.m.	1:49	88	0	26
7/29/22 3:45 p.m.	4:00	87	0	7
8/31/22 11:00 p.m.	11:20	88	0	6
10/7/22 11:00 a.m.	11:13	88	0	(blank)

The home combined the monthly fire drills in conjunction with another licensing entity not regulated by this Department.

Plan of Correction

Accept [redacted] - 12/05/2022)

An annual fire drill was conducted 10/14/22 with President of local Harmony Fire District and the Maintenance Director and Administrator. This was held only for the personal care home residents. This Fire Drill occurred as well to account for the abovementioned 10/7/22 monthly fire drill listed as incomplete/blank. This fire drill was conducted successfully in 3 minutes and 30 seconds with all residents participating. Based on education provided at annual site survey on 10/12/22, protocols for ongoing monthly/annual Fire Drills have been clarified with Administrator and Maintenance Director. On 10/14/22, Administrator and Maintenance Department established a monthly fire drill schedule through the end of calendar year 2023. Starting 10/14/22, Administrator will review quarterly to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [redacted] - 12/23/2022)

144c2 - Smoking Area Distance

13. Requirements

2600.

144c2 Smoking Area Distance (continued)

- 144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
 - 2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

On 10/12/22, at approximately 12:45 p.m., an agent of the Department observed resident #2 smoking on a bench approximately fifteen feet from the entrance of the home. This was not the designated smoking area. The designated smoking area is in the gazebo in the courtyard.

Plan of Correction

Accept (████) - 12/05/2022)

On 10/14/22, Administrator and Maintenance Department placed "No Smoking" signs 20 feet from entrance door. 10/14/22, Administrator provided all residents with additional education to clarify the designated smoking area location, route, and times. On 10/14/22, All smoking residents confirmed understanding verbally with Administrator. As of 10/16/22, Administrator and Maintenance Director will include an audit of the current smoking policy and sign placement with quarterly review beginning 10/16/22.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented (████) - 12/23/2022)

184a - Resident's Meds Labeled

14. Requirements

- 2600.
- 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

On █████, resident #3 was ordered █████, 1 tablet daily; however, the medication label indicates "One tablet by mouth twice daily."

Plan of Correction

Accept (████) - 12/05/2022)

On 10/13/22, Administrator clarified the █████ order for Resident 3# with Certified Registered Nurse Practitioner. On 10/16 it was determined that Administrator and MT will perform weekly medication reconciliation audits of the medication cart and eMAR medication lists with quarterly audit reviews beginning on 10/16/22.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented (████) - 12/23/2022)

225a - Assessment 15 Days

15. Requirements

- 2600.
- 225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

225a - Assessment 15 Days (continued)

Description of Violation

On 10/12/22 it was observed that while resident #3 was admitted to the home on [REDACTED] however, the initial assessment was undated as to when the assessment was completed. Additionally, the mental health section was blank.

Plan of Correction

Accept ([REDACTED] - 12/05/2022)

On 10/12/22, Administrator dated the Admissions Assessment with [REDACTED] to reflect Resident #3's admission date. On 10/14/22, Administrator included mental health assessment section with POA and Resident #3. Following Administrator's initial review on 10/14/22 Administrator will conduct quarterly audits will occur thereafter (from 10/14/22) to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([REDACTED] - 12/23/2022)

227a - Support Plan 30 Days

16. Requirements

2600.

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

Description of Violation

On 10/12/22 it was observed that while resident #3 was admitted to the home on [REDACTED]; the initial support plan was undated as to when the support plan was completed.

Plan of Correction

Accept ([REDACTED] - 12/05/2022)

On 10/12/22, Administrator dated RASP with 9/9/22 to reflect Resident #3's admission date. Following Administrator's initial review on 10/14/22, and starting 10/14/22, Administrator will review quarterly to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([REDACTED] - 12/23/2022)

227d - Support Plan Medical/Dental

17. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

On 10/12/22, resident #3's medication assessment indicated that this resident requires assistance remembering schedule, offering medications at prescribed times, and assistance in opening container or locked storage area; however, the support plan was blank and did not address the description of medication needs, the plan to meet medication needs nor the responsible party who will assist with meeting these needs.

Plan of Correction

Accept ([REDACTED] - 12/05/2022)

On 10/14/22, Administrator amended RASP to address Resident #3's near total [REDACTED], and verbally confirmed

227d - Support Plan Medical/Dental (continued)

understanding. Following Administrator's initial review on 10/14/22 Administrator will conduct quarterly audits (from the date of 10/14/22) will occur thereafter to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

227g -Support Plan Signatures**18. Requirements**

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

On 10/12/22, the undated support plan for resident #3 were not dated by the staff member who completed the assessment.

Plan of Correction

Accept [REDACTED] - 12/05/2022)

On 10/14/22, Administrator dated RASP to reflect admissions date of [REDACTED] and was signed by Resident #3's POA and includes a notation to reflect Resident #3's near total blindness and confirmed verbal understanding. Following Administrator's initial review on 10/14/22 Administrator will conduct quarterly audits (from the date of 10/14/22) will occur thereafter to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

227h - Support Plan Refuse Sign**19. Requirements**

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

On 10/12/22, the undated support plan for resident #3's indicated that both the resident and the POA participated in the assessment and support plan process; however, neither the resident nor the POA signed the support plan nor does the form indicate an inability or refusal to sign. Additionally, there was no date indicating when the resident and POA participated in this process.

Plan of Correction

Accept [REDACTED] - 12/05/2022)

On 10/14/22, The Admissions Contract for Resident #3 was amended by Administrator to reflect original admission date of [REDACTED] in conjunction with resident and Designated POA, and a notation reflecting Resident #3's near total vision impairment and confirmed verbal understanding. Following Administrator's initial review on 10/14/22 Administrator will conduct quarterly audits (from the date of 10/14/22) will occur thereafter to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented [REDACTED] - 12/23/2022)

251b - Record Entries Legible

20. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

On 10/11/22 it was observed that correction fluid was used on resident #3's undated initial resident assessment and support plan (RASP) in the following sections:

The area code provided for the case manager located under the telephone section and under the formal support section on page 1, in Part I: resident information.

The support plan section in the description of service need and the plan to meet the service need regarding caring for personal possessions on page 4.

The support plan section under [redacted] enjoy" in the resident enjoys the following solitary activities on page 11.

The support plan section under [redacted] in the resident enjoys the following solitary activities on page 11.

Plan of Correction

Accept [redacted] - 12/05/2022)

On 10/14/22, Administrator amended RASP to reflect no use of correction fluid and/or misspellings. Following Administrator's initial review on 10/14/22 Administrator will conduct quarterly audits will occur (from the date of 10/14/22 thereafter to ensure completeness.

Licensee's Proposed Overall Completion Date: 12/01/2022

Implemented ([redacted] - 12/23/2022)