

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

Facility Information

Name: *ARK MANOR* License #: *44686* License Expiration: *02/10/2023*
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: *36* Waking Staff: *27*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Monitoring* Exit Conference Date: *11/10/2022*

Inspection Dates and Department Representative

11/08/2022 - On-Site: [REDACTED]
11/09/2022 - On-Site: [REDACTED]
11/10/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* Residents Served: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *16* Are 60 Years of Age or Older: *28*
Diagnosed with Mental Illness: *16* Diagnosed with Intellectual Disability: *4*
Have Mobility Need: *3* Have Physical Disability: *0*

Inspections / Reviews

11/08/2022 - Full

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*Follow Up Date: *12/11/2022*

12/12/2022 POC Submission

Submitted By: [REDACTED]

Date Submitted: *01/31/2023*

Reviewer: [REDACTED]

Follow Up Type: *POC Submission*Follow Up Date: *12/16/2022*

12/20/2022 POC Submission

Submitted By: [REDACTED]

Date Submitted: *01/31/2023*

Reviewer: [REDACTED]

Follow Up Type: *Document Submission*Follow Up Date: *01/31/2023*

02/23/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: *01/31/2023*

Reviewer: [REDACTED]

Follow Up Type: *Enforcement*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 11/8/22, the following license inspection summaries were not posted in a conspicuous and public place in the home:

- License inspection summary, dated 11/2/21, et. al.
- License inspection summary, dated 2/15/22, et. al.
- License inspection summary, dated 3/14/22
- License inspection summary, dated 5/2/22, et. al.
- License inspection summary, dated 6/8/22

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

Plan of Correction

Accept (redacted) - 12/16/2022)

License inspection summary dated 11/21/21, 2/15/22, 3/14/22, 5/2/22 and 6/8/22 posted by Administration in a conspicuous public place in the home immediately on 11/08/2022 while inspectors were on site.

Administration/ assistant will ensure after each inspection the summary is posted. Sanswrite will be reviewed monthly x 6 months beginning 11/11/22 and use as a guide to show all inspections required to be posted.

Admin/ assistant will check monthly x 6 months beginning 11/11/22 to ensure the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home. documentation of the checks will be kept.

Licensee's Proposed Overall Completion Date: 12/13/2022

Implemented (redacted) - 02/23/2023)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 11/8/22 at approximately 9:00 am, then again at 4:20 pm, the medication office was unlocked, unattended and accessible. The medication room contained unlocked assessment and support plans for numerous residents, to include residents #1, #2, and #3.

REPEAT VIOLATION: 2/15/2022, et. al.

Plan of Correction

Accept (redacted) - 12/16/2022)

The medication room door was locked immediately when state inspectors notified admin assistant on 11/8/22 and on 11/11/2022 the staff re educated by Administrative Assistant on 2600.17.

Documentation of training kept.

17 - Record Confidentiality (continued)

beginning 12/9/2022 The med tech scheduled for each shift will be responsible for ensuring that all resident records always remain confidential and that confidential areas remain locked and off limits. Administration or Designee will do random checks of the med room minimally of 4 times per week beginning 12/9/22 to be sure it is locked. If it is found to be unlocked it will warrant a right up of the med tech in charge along with additional training

Licensee's Proposed Overall Completion Date: 12/13/2022

Implemented [REDACTED] - 02/23/2023)

18 Compliance With Laws**3. 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 11/8/22, no Influenza poster was posted in a conspicuous and public place in the home in accordance with the Influenza Awareness Act, enacted in July, 2016.

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 9/23/16, indicates if a carbon monoxide alarm at a care facility operates by battery, the battery shall be labeled with the date of installation and replaced at least once annually. However, the batteries in the carbon monoxide detector located in the stairwell to the basement were undated.

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

Plan of Correction

Directed [REDACTED] 12/16/2022)

1. On 11/8/2022 while inspectors were on site, the Influenza poster was moved by Administrative Assistant to a more conspicuous, public place in the home. Administration / assistant will check monthly x 6 months beginning 11/11/22 to ensure the Influenza poster remains in a conspicuous and public place. Documentation of these checks will be kept.

B. All batteries in the facility's Carbon Monoxide alarms changed and labeled by Administrative Assistant on 12/5/2022. A written log will also be kept by administration / assistant to confirm the battery changes, A calendar was produced by admin / assistant as a reminder of when batteries will be changed. admin / assistant will reference this calendar monthly to review reminders for the month to remain in compliance. (DIRECTED: The monthly review of the calendar shall begin on 1/1/23 to ensure the batteries in all carbon monoxide detectors are changed at least annually and are labeled with the date of installation. [REDACTED] 12/16/22).

Directed Completion Date: 01/01/2023

Not Implemented [REDACTED] - 02/23/2023)

20b8 - Quarterly Account

4. Requirements

2600.

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

- 8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home manages finances for residents #4 and #5; however, residents #4 and #5, as well as their designated persons, have not received an itemized account of financial transactions for over a year.

Plan of Correction

Directed (█ - 12/16/2022)

On 11/23/2022 the assistant administrator provided an itemized account of the financial transactions made on the resident's behalf to the resident and their designated person for all residents and their designated person including resident's #4 and #5. The administrator / assistant will continue to provide this information to the resident and their designated person on a quarterly basis. Calendar made as a reminder and will be reviewed monthly by admin / designee to ensure compliance. Documentation will be kept. (DIRECTED: The monthly review of the calendar shall begin on 1/1/23 to ensure each resident and their designated person receive an itemized account of financial transactions made on the resident s behalf on a quarterly basis for all residents the home is currently managing inances for. █ 12/16/22).

Directed Completion Date: 01/01/2023

Not Implemented (█ - 02/23/2023)

26b - Quality Management Plan Content

5. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

- 1. The reportable incident and condition reporting procedures.
- 2. Complaint procedures.
- 3. Staff person training.
- 4. Licensing violations and plans of correction, if applicable.
- 5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review, conducted on 8/1/22, does not include a review of reportable incident and conditions, complaint procedures, and staff person training.

Plan of Correction

Directed (█ - 12/16/2022)

On 12/6/2022 a quality management review was conducted by Administration and 2 Staff members During this review the following were included in the meeting: reportable incident and condition reporting procedures, complaint procedures, Staff training. Licensing violations and plans of correction.

26b - Quality Management Plan Content (continued)

Calendar made as a reminder and will be reviewed monthly by admin / designee to ensure compliance.

DIRECTED: The monthly review of the calendar shall begin on 1/1/23 to ensure a quality management review of all topics specified in 2600.26b is conducted at least annually. [REDACTED] 12/16/22).

Quality Management plan will be done minimally of yearly. documentation will be kept.

Directed Completion Date: 01/01/2023

Not Implemented [REDACTED] - 02/23/2023)

51 - Criminal Background Check**6. 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 on [REDACTED]; however, a Pennsylvania criminal background check was not completed for staff person A until 4/11/22.

REPEAT VIOLATION: 2/15/2022, et. al.; 9/17/2021, et. al.

Plan of Correction

Directed [REDACTED] - 12/16/2022)

On 10-01-2022 all employee charts were audited by Administration to ensure compliance.

Administrator / assistant is responsible for completing background checks. Admin / assistant will complete all new employee criminal background checks directly upon hire. In order to assure compliance the Employee file checklist will be kept on Administration desk to be reviewed daily until all regulatory items are complete. (DIRECTED: The administrator's daily review of the checklist shall begin within 72 hours of receipt of the plan of correction. [REDACTED] 12/16/22). Once complete the employee chart will be filed. On 12/12/22 Admin and assistant were reeducated on 2600.51 and 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). (DIRECTED: Documentation of the education shall be kept. [REDACTED] 12/16/22).

Directed Completion Date: 12/16/2022

Not Implemented [REDACTED] - 02/23/2023)

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.

65d - Initial Direct Care Training *(continued)*

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

Direct care staff person A, hired on [REDACTED], began providing unsupervised ADL services to residents on 3/5/22. However, direct care staff person A did not successfully complete and pass the Department-approved direct care training course and pass the competency test until 3/17/22.

REPEAT VIOLATION: 6/8/2022

Plan of Correction

Directed [REDACTED] - 12/16/2022)

*All new staff will complete training prior to being scheduled to provide any resident care.
 On 10-01-2022 all employee charts were audited by Administration to ensure compliance.
 Administrator / assistant will complete all new employee training directly upon hire and prior to new direct care staff providing any unsupervised ADL services to the residents. In order to ensure compliance the employee file checklist will be kept on Administration desk until all regulatory items are complete. It will be reviewed daily until complete, then filed in file. (DIRECTED: The administrator's daily review of the checklist shall begin within 72 hours of receipt of the plan of correction. [REDACTED] 12/16/22).
 on 12/12/22 admin and assistant were re educated on 2600.65.d. (DIRECTED: Documentation of the education shall be kept. [REDACTED] 12/16/22).*

Directed Completion Date: 12/16/2022

Not Implemented [REDACTED] - 02/23/2023)

85a - Sanitary Conditions

8. Requirements

2600.

85a - Sanitary Conditions (continued)

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/8/22 at 10:05 am, there were numerous open and unlabeled personal hygiene items, such as shampoo, conditioner and body wash, present in the shower of the common shower room next to bedroom [REDACTED]. Also, an unlabeled and used razor was present in the common shower.

On 11/8/22 at 10:06 am, there was [REDACTED] matter smeared on the wall and the handrail to the left of the toilet in the common shower room next to bedroom #303.

On 11/10/22 at approximately 11:15 am, there were numerous spots of feces on the wall in the shared bathroom between bedrooms [REDACTED] and [REDACTED]. Also, there was an unlabeled gray hairbrush and a storage caddy that included numerous unlabeled razors, toothbrushes, shampoos and hairbrushes.

On 11/10/22, there were numerous spots of [REDACTED] on the wall and toilet seat in resident #6's shared bathroom.

On 11/10/22 at approximately 1:30 pm, there was a strong, pungent odor of urine in bedroom [REDACTED] and in the hallway corridor outside of bedroom #302.

REPEAT VIOLATION: 5/2/2022, et. al.; 2/15/2022, et. al.; 9/17/2021, et. al.

Plan of Correction

Directed [REDACTED] - 12/16/2022)

All staff re educated by Administration on 2600.85.a and new daily routine to ensure compliance on 12/5/2022. documentation kept and sign off sheet for daily checks introduced to staff for immediate use beginning 12/6/2022

Med Techs and direct care staff are now assigned specific job duties each day to ensure sanitary conditions are being maintained which includes each staff being assigned specific areas of the building (common areas, shower rooms, resident bedrooms, resident's bathrooms) to inspect and ensure sanitary conditions are being met- and clean specific areas as needed to ensure compliance. Administration / assistant will walk do a complete walk through of the facility each day she is scheduled beginning 12/9/22 to ensure sanitary conditions ae being maintained. Documentation of the checks will be kept.

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall develop and mplement procedures to ensure personal hygiene items, including body wash, shampoo, hair brushes and razors are organized and labeled with each resident's name or stored in separate bins which are labeled with each resident's name. All staff persons shall be educated on the new procedures within 10 calendar days of receipt of the plan of correction. Documentation of the education shall be kept. [REDACTED] 12/16/22

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall inspect all areas of the home, ncluding the areas indicated in this license inspection summary for 2600.85a, to ensure all areas are clean and that sanitary conditions are maintained. [REDACTED] 12/16/22

Directed Completion Date: 12/26/2022

Not Implemented [REDACTED] - 02/23/2023)

85a - Sanitary Conditions (continued)

9. Requirements

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

Description of Violation

On 10/22/22 at 8:41 am, resident #11's glucometer was used to test resident #6's blood glucose.

On 10/24/22 at 8:35 am, resident #10's glucometer was used to test resident #9's blood glucose.

On 10/27/22 at 7:49 am, resident #2's glucometer was used to test resident #9's blood glucose.

On 11/4/22 at 7:00 am, resident #9's glucometer was used to test resident #2's blood glucose.

On 11/5/22 at 7:31 am, then again at 5:50 pm, resident #14's glucometer was used to test resident #6's blood glucose.

Plan of Correction

Directed (████ - 12/16/2022)

resident's PCPs were notified that glucometers were shared for all cited residents on 12/2/2022. All DHS med techs were re educated by Administrative Assistant on 2600.85.a - Sanitary conditions shall be maintained- Specifically during this re education staff reminded of the issues and severity with using any diabetic supply (including but not imited to glucose meters) between any residents. (DIRECTED: Documentation of the staff education shall be kept. █████ 12/16/22). Staff is re educated that each diabetic resident is to have their own glucose meter and gucose checking supplies and that the meter and the supplies are to never be shared between residents. Upon review of Glucometers and readings, it was found that a glitch in the Tabula pro program was recording glucose readings in random times. Tabula pro said it was happening in other Facilities and is now corrected.

Observation for each diabetic trained staffed done initially during the week of 11/13-11/19/2022 by admin / assitant. This observation confirmed the correct meter was used for each resident and that the glucose reading was documented correctly on the MAR. Observations will be conducted for each diabetic trained staff weekly x 1 month then once monthly x 2 months. Documentation of the observations will be kept by administrator / assistant. DIRECTED: The weekly observations shall begin within 5 calendar days of receipt of the plan of correction. █████ 12/16/22).

Directed Completion Date: 12/18/2022

Not Implemented (████ 02/23/2023)

85b - Infestation

10. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

85b - Infestation (continued)

Description of Violation

On 11/10/22 at 1:18 pm, numerous flies were observed flying around the bedroom and swarming around the ceiling fan in the shared bedroom of residents #6 and #8.

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

Plan of Correction

Accept (█ - 12/16/2022)

Ehrlich pest control was contacted immediately by Administrative Assistant and came in to provide service on November 10, 2022 which included spraying the flies observed in resident's #6 and #8 and other areas through out the facility. All Staff were reminded to report any sign of infestation to Administration. Ehrlich recommends that we continue with monthly treatments and is expected to follow up with services monthly. Documentation of their services will be kept.

Licensee's Proposed Overall Completion Date: 12/13/2022

Not Implemented (█ - 02/23/2023)

85e Trash Outside Home

11. 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

On 11/8/22 at approximately 12:15 pm, there was an uncovered 30-gallon trash can next to the home's grill under the covered patio, which was completely full of trash.

REPEAT VIOLATION: 7/20/2022; 9/17/2021, et. al.

Plan of Correction

Accept (█ 12/16/2022)

The trash can was immediately emptied by DCS while inspectors were on site 11/8/2022 and the rest of the remaining areas outside were initially checked then as well by staff member █ to ensure compliance.

Staff was re educated by Administration on 2600.85.e and DCS, █ has been assigned to check the outside grounds of the facility to ensure compliance minimally of twice per week beginning 12/12/2022. In the even █ unavailable to complete these checks, admin / assistant will take responsibility of completing this task. Documentation of these checks will be kept x 6 months.

Licensee's Proposed Overall Completion Date: 12/13/2022

Not Implemented (█ - 02/23/2023)

86b - Bathroom

12. Requirements

2600.

86b - Bathroom (continued)

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 11/10/22, the exhaust fan in the shared bathroom of resident #6 was inoperable. No operable window is present in the shared bathroom.

Plan of Correction

Accept (█ - 12/16/2022)

maintenance completed repair of resident's #6 exhaust fan on 12/12/2022. A walk through of all other bathrooms to ensure compliance was completed by maintenance on 12/9/2022. additional checks will be completed minimally of monthly beginning 12/12/2022 and will include checking all bathrooms.

Licensee's Proposed Overall Completion Date: 12/13/2022

Not Implemented (█ - 02/23/2023)

88a - Surfaces

13. 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 11/8/22, there were 4 ceramic floor tiles with numerous cracks and chips present in the home's medication room. Also, 5 of the ceramic floor tiles are loose and separated from the grout.

On 11/8/22, an approximate 1/2"-1/4" gap is present at the top of the exit door leading to the home's parking lot and was not flush with the door frame.

On 11/8/22, the exit door next to the home's common shower room is splintered and the weather stripping is partially detached and hanging from the door frame.

The "blue hallway", which includes approximately 8 bedrooms, has been under active construction since around 4/5/22. As of 11/10/22, the blue hallway is still under construction and construction materials and construction debris are present throughout the blue hallway. Also, the drywall is missing from the bottom half the walls on both sides of the hallway.

REPEAT VIOLATION: 7/20/2022; 9/17/2021, et. al.

Plan of Correction

Directed (█ - 12/16/2022)

- The floor in the medication room was completely replaced on 12/2/2022 by Maintenance staff.
- The exit door leading to the parking lot and near the common shower room were repaired on 12/9/2022 by Maintenance staff
- The construction debris and materials have been cleaned. While construction is undergoing, there is a locked room at the end of the hallway the contractors will use for materials until renovation is complete.
- future repairs will be done by maintenance promptly. There are now 2 contacts for maintenance repairs.

88a - Surfaces (continued)

-admin / assistant will do daily walk through of facility each day [REDACTED] is in the facility to ensure compliance and report any issues to maintenance promptly. (DIRECTED: The administrator daily walkthroughs shall begin within 48 hours of receipt of the plan of correction. [REDACTED] 12/16/22).

-A maintenance request form has been produced for staff to fill out and return to admin for future maintenance needs. Staff educated on 12/13/22 by assistant admin. Documentation of this education will be kept.

DIRECTED: By 1/31/23: The missing drywall from the bottom half of the walls on both sides of the blue hallway shall be repaired. [REDACTED] 12/16/22).

Directed Completion Date: 01/31/2023

Not Implemented [REDACTED] - 02/23/2023)

100a - Exterior - Free of Hazards**14. Requirements**

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 11/9/22 at 9:00 am, the light fixture was detached and hanging from the outdoor light post and was wrapped in a plastic garbage bag.

REPEAT VIOLATION: 2/15/2022, et. al.

Plan of Correction

Accept [REDACTED] - 12/16/2022)

On 12/5/2022 the light fixture on the exterior of the building was repaired by Maintenance staff and he inspected the exterior of the home to ensure there were no additional hazards.

Staff was re educated on 12/5/22 by Administration on 2600.100.a and DCS, [REDACTED], has been assigned to check the outside grounds of the facility to ensure compliance minimally of twice per week beginning 12/12/2022. In the event [REDACTED] is unavailable to complete these checks, admin / assistant will take responsibility of completing this task. Documentation of these checks will be kept x 6 months.

-A maintenance request form has been produced for staff to fill out and return to admin for future maintenance needs to ensure exterior of the home is free of hazard. Staff educated on 12/13/22 by assistant admin. Documentation of this education will be kept.

Licensee's Proposed Overall Completion Date: 12/13/2022

Not Implemented [REDACTED] - 02/23/2023)

101j7 - Lighting/Operable Lamp**15. Requirements**

2600.

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

101j7 - Lighting/Operable Lamp (continued)

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 11/10/22, no operable lamp or other source of lighting that can be turned on/off from bedside was present in resident #8's bedroom.

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

Plan of Correction

Directed (redacted) - 12/16/2022)

Lamp placed in resident #8's room on 11/11/22. DCS, (redacted), did a complete walk through of all bedrooms to ensure an operable lamp or other source of light that can be turned on at bedside was accessible for all residents on 12/9/2022. beginning 12/9/22 she will monitor weekly x 6 months (UNACCEPTABLE PORTION OF PLAN OF CORRECTION (redacted) 12/16/22). The weekly monitoring shall continue indefinitely to ensure each resident has an operable lamp or other source of lighting that can be turned on/off at bedside. (redacted) 12/16/22). Documentation of the checks will be kept. Staff educated by assistant admin on 2600.101j on 12/12/22. (DIRECTED: Documentation of the education shall be kept. (redacted) 12/16/22).

Directed Completion Date: 12/16/2022

Not Implemented (redacted) - 02/23/2023)

103f - Refrigerator/Freezer Temps

16. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 11/8/22 at 10:20 am, the thermometer in the home's walk-in freezer was inoperable. No other operable thermometer was present in the freezer.

Plan of Correction

Accept (redacted) - 12/16/2022)

New, operable thermometers were placed in the walk in cooler and freezer on 11/14/22 by Administration Administrator / assistant will check the thermometers weekly x 6 months beginning 11/14/22 to ensure the thermometers are in good working condition. Documentation of these checks will be kept.

Staff educated on 12/12/22- 2600.103.f

Licensee's Proposed Overall Completion Date: 12/13/2022

Not Implemented (redacted) - 02/23/2023)

121a - Unobstructed Egress

17. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 11/8/22 at 9:53 am, a metal framed chair was wedged under the door handle of the emergency exit door located

121a - Unobstructed Egress (continued)

in the sun room. The chair was wedged under the door on the exterior side of the home, preventing egress from the home.

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

Plan of Correction**Directed** [REDACTED] - 12/16/2022)

Chair immediately removed on 11/8/22.

Staff re educated by Administration on 2600.121.a on 12/2/2022 (DIRECTED: Documentation of the education shall be kept. [REDACTED] 12/16/22).

At the beginning of each shift, the med tech will walk through the facility to ensure all egresses are unobstructed beginning 12/12/22. Documentation of these checks will be kept x 2 months.

Staff educated on 12/12/22 on 2600.121.a (DIRECTED: Documentation of the education shall be kept. [REDACTED] 12/16/22).

Directed Completion Date: 12/16/2022

Not Implemented [REDACTED] - 02/23/2023)**123b - Emergency Procedures Posted****18. Requirements**

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 11/8/22, the emergency preparedness procedures for Salem Township and Westmoreland County were secured in the administrator's office and were not posted in a public and conspicuous place in the home.

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

Plan of Correction**Accept** [REDACTED] - 12/16/2022)

On 11/8/2022, while the inspectors were on site, admin assistant immediately posted the emergency preparedness procedure for Salem Township and Westmoreland County in a conspicuous and public place in the home.

The administrator / assistant will check monthly beginning 11/8/22 x 6 months to ensure copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) are posted in a conspicuous and public place in the home . Documentation will be kept.

Licensee's Proposed Overall Completion Date: 12/13/2022

Implemented [REDACTED] - 02/23/2023)**130g - Smoke Detector Repair****19. Requirements**

130g - Smoke Detector Repair (continued)

2600.

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

Description of Violation

On 11/8/22, the home's fire system panel was beeping and the "trouble" light was illuminated on the panel. According to multiple staff persons, the fire system panel has been beeping with the trouble light illuminated for approximately 1 month.

REPEAT VIOLATION: 6/8/2022

Plan of Correction

Directed [REDACTED] - 12/20/2022)

On 11-10-2022, staff immediately implemented the facility's emergency policy and procedure for an inoperable smoke detector or fire alarm. Per this procedure, in the event a fire alarm or smoke detector is inoperable, mandatory walk through of the building will be done minimally of every half an hour. The walk through will be through the entire building and will include any area(s) of the home that may not be in use or under renovation. Documentation of the walk through checks will be done by staff until fire alarms and smoke detectors are maintained and working without issue. In the event that an emergency occurs while this policy and procedure is in place, such as a fire, staff is to call 911 immediately. Staff was educated by Administration on this procedure on 11-10-2022. All staff was educated by admin directly after procedure was created. documentation of education will be kept.

Facility has been in contact with MVS security Services and the vendor will be making the repairs to the facility's fire panel.

[REDACTED] UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [REDACTED] 12/20/22)

DIRECTED: Within 48 hours of receipt of the plan of correction: All repairs to the home's fire system panel shall be made by a qualified professional. Documentation of the repairs shall be kept. [REDACTED] 12/20/22

Directed Completion Date: 12/22/2022

Not Implemented [REDACTED] 02/23/2023)

130h - Inoperable Smoke Detector

20. Requirements

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction

Directed [REDACTED] 12/20/2022)

On 11 10 2022 admin created emergency policy and procedure for an inoperable smoke detector or fire panel,

130h - Inoperable Smoke Detector (continued)

staff immediately educated on this policy/ procedure on 11-10-22 and implemented the facility's emergency policy and procedure for an inoperable smoke detector or fire alarm. Documentation of education will be kept. Per this procedure, in the event a fire alarm or smoke detector is inoperable, mandatory walk through of the building will be done minimally of every half an hour. The walk through will be through the entire building and will include any area(s) of the home that may not be in use or under renovation. Documentation of the walk through checks will be done by staff until fire alarms and smoke detectors are maintenance and working without issue. In the event that an emergency occurs while this policy and procedure is in place, such as a fire, staff is to call 911 immediately. Staff was educated on this procedure by Administration on 11-10-2022.

Facility has been in contact with MVS security Services and the vendor will be making the repairs to the facility's fire panel. [REDACTED] — (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [REDACTED] 20/22).

DIRECTED: Within 48 hours of receipt of the plan of correction: All repairs to the home's fire system panel shall be made by a qualified professional. Documentation of the repairs shall be kept. [REDACTED] 12/20/22

Directed Completion Date: 12/22/2022

Not Implemented ([REDACTED] - 02/23/2023)

132f Alternate E it Routes**21. Requirements**

2600.
132.f. Alternate e it routes shall be used during fire drills.

Description of Violation

The "main" and "green" exits were the only exits used for the following 5 consecutive fire drills:

- 6/6/22 at 4:15 pm
- 7/12/22 at 9:15 am
- 8/26/22 at 6:00 pm
- 9/12/22 at 10:20 am
- 10/10/22 at 4:45 am

Plan of Correction

Accept ([REDACTED] 12/12/2022)

On 11/16/2022 a fire drill was conducted. Exits wing 4 north and red hall was used.
On 12/2/2022 a fire drill was conducted. Exits wing 4 south and green hall exit was used.

Administrator / assistant will verify on the fire drill record, prior to each months drill, that an alternate exit is being used and will document such on the fire drill record. To help with using alternate exits, the Administration will put the exits to be used on the log for a 6 month period at a time

132f - Alternate Exit Routes (continued)

Licensee's Proposed Overall Completion Date: 12/09/2022

Not Implemented [REDACTED] - 02/23/2023)

141a 1 10 Medical Evaluation Information

22. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #12’s most recent medical evaluation, dated [REDACTED], does not include the medical professional's name. This section of the evaluation is blank.

REPEAT VIOLATION: 2/15/2022, et. al.; 9/17/2021, et. al.

Plan of Correction

Directed [REDACTED] 12/16/2022)

All of the resident's charts were audited by Administration to ensure all compliance with 2600.141.a.

Chart audits comepleted 12/9/2022. The medical professionals name was added to resident #12's medical evaluation.

n the future, After medical eval is completed by medical professional, admin / assistant will review to ensure it is completed in entirety, prior to filing in the resident's chart. (DIRECTED: The administrator/assistant review shall be completed within 48 hours after each resident's medical evaluation is completed. [REDACTED] 12/16/22). A resident file checklist is attached to each chart. (DIRECTED: Within 48 hours of receipt of the plan of correction: The checklist shall be implemented for all new admissions to ensure a medical evaluation is completed in its entirety within 60 days prior to admission or within 30 days after admission for all newly-admitted residents. Copies of the completed checklists shall be kept in each resident's record. [REDACTED] 12/16/22).

Admin / assistant re educated on 2600.141.a on 12/12/22- documentation will be kept.

Directed Completion Date: 12/18/2022

Not Implemented ([REDACTED] - 02/23/2023)

141b1 - Annual Medical Evaluation

23. Requirements

141b1 - Annual Medical Evaluation (*continued*)

2600.

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 [REDACTED]; however, resident #1's previous medical evaluation was completed on 7/12/21.

Resident #3's most recent medical evaluation was completed on [REDACTED]; however, resident #3's previous medical evaluation was completed on 5/21/21.

Resident #13's most recent medical evaluation was completed on [REDACTED]; however, resident #13's previous medical evaluation was completed on 5/3/21.

REPEAT VIOLATION: 7/20/2022; 2/15/2022, et. al.; 9/17/2021, et. al.

Plan of Correction

Directed [REDACTED] 12/16/2022)

In August 2022, all resident charts were audited by Administration to ensure medical evaluations were completed per regulation.

Administrator / assistant has produced a calendar to reference when medical evaluations are due for each resident. Administrator / assistant will refer to this calendar monthly to ensure compliance with 260.141.b.1 and admin / assistant will be responsible for keeping the calendar updated. (DIRECTED: Within 48 hours of receipt of the plan of correction: The calendar shall be reviewed by the administrator weekly for 3 months, then monthly thereafter, to ensure the calendar is current and to ensure a medical evaluation is completed for each resident, at least annually. [REDACTED] 12/16/22). Both the administrator and the admin assistant will review charts monthly beginning in December 2022 to ensure compliance. documentation of these checks will be kept.

Directed Completion Date: 12/18/2022

Not Implemented ([REDACTED] - 02/23/2023)

183b - Meds and Syringes Locked

24. 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 11/8/22 at 9:00 am, then again at 4:20 pm, the home's medication cart was unlocked, unattended, and accessible. Numerous medications for numerous residents, to include the following, were present in the unlocked medication cart:

- Resident #1's Mirtazapine 7.5 mg and Trazadone 50 mg
- Resident #2's Amlodipine 10 mg and Bupropion 100 mg
- Resident #3's Tramadol 50 mg and Lorazepam 1 mg

REPEAT VIOLATION: 5/2/2022, et. al.; 2/15/2022, et. al.; 11/2/2021, et. al.; 9/17/2021, et. al.

183b - Meds and Syringes Locked (continued)

Plan of Correction

Directed [REDACTED] 12/16/2022)

Medication cart was secured immediately on 11/8/22 after exit interview with state inspectors.

On 12/5/2022 all DHS med techs were re educated by Administration on 2600.183.b- this education reviewed the need for all medications to remain locked at all time, except during medication administration. Documentation of teducation will be kept.

During this re education med tech staff were instructed that the DHS med tech on duty each shift is responsible to ensure compliance with 2600.183.b and failure to do so will result in an employee write up. (DIRECTED: The med tech on duty shall inspect the home, including all medication carts and storage areas, each shift to ensure all prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked.

Documentation of the audits shall be [REDACTED] 12/16/22). Plan for correction to be instated immediately upon education (12/5/22) Administration will do random checks, minimally of 3 times per week- during this check admin / assistant will locate the med carts in the facility and ensure they are locked to remain in complaiance with 2600.183.b. If not in compliance, it will result in write up for med tech in charge. Audits to begin 12/9/22 x 2months- documentation will be kept.

Directed Completion Date: 12/16/2022

Not Implemented [REDACTED] - 02/23/2023)

185a - Implement Storage Procedures

25. 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 #1 is prescribed Epinephrine 0.3 mg-Inject intramuscularly as directed for allergic reactions; however, this medication was not available in the home on 11/9/22.

Resident #2 is prescribed blood glucose checks once daily. However, there are no blood glucose readings documented on resident #2's October 2022 medication administration record (MAR) and November 2022 MAR on numerous dates, to include on 10/12/22, 10/19/22, 10/22/22, 10/23/22, 11/6/22 and 11/7/22.

On 10/12/22 at approximately 4:00 pm. resident #11's blood glucose was 163; however, resident #11's blood glucose was documented as 89 on resident #11's October 2022 MAR.

On 10/21/22 at approximately 4:30 pm, resident #11's blood glucose was 103; however, resident #11's blood glucose was documented as 163 on resident #11's October 2022 MAR.

On 10/24/22 at approximately 5:30 pm, resident #11's blood glucose was 162; however, resident #11's blood glucose was documented as 167 on resident #11's October 2022 MAR.

Resident #11 is prescribed blood glucose checks once daily on Monday, Wednesday, Friday and as needed. However, there is no blood glucose reading documented on resident #11's November 2022 MAR for Monday, 11/7/22.

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept [REDACTED] 12/16/2022)

Administration -consulted resident #1 PCP in regards to epinephrine not being in house- per PCP, epi discontinued on 11/10/22. Med Tech staff will complete full audits for each resident minimally of every 60 days- documentation of these audits will be kept on tabula pro.

-DHS med techs reeducation by Administration and outside agency, Viaquest on 12/5/22. Documentation will be kept. diabetes education including documentation of glucose readings and following orders from MD. Observation for each diabetic trained staffed done initially during the week of 11/13-11/19/2022 by admin / assistant. This observation confirmed the correct meter was used for each resident and that the glucose reading was documented correctly on the MAR. Observations will be conducted for each diabetic trained staff weekly x 1 month then once monthly x 2 months beginning 11/13/22. Documentation of the observations will be kept by administrator / assistant.

-Administrator / assistant also conducting 3 additional blood glucose audit per week (beginning 11/13/22) to ensure the correct meter is being used with each diabetic resident and that documentation is true and accurate. Will conduct audit 3 times per week x 1 month. documentation will be kept.

-Please note, after inspectors were on site and admin / assistant were reviewing possible violations, it was discovered that when staff was documenting glucose readings the vital was being recorded incorrectly on the MAR.due to a glitch in the Tabula pro program. When admin contacted tabula pro, they agreed the glitch was causing glucose levels to be entered in random places on the MAR. All vitals are now showing appropriately on the MARs.

Licensee's Proposed Overall Completion Date: 12/15/2022

Not Implemented [REDACTED] - 02/23/2023)

185b - Medication Procedures

26. Requirements

2600.

185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

On 11/8/22 at 9:00 am, then again at 4:20 pm, the narcotic drawer was unlocked, unattended and accessible in the unlocked medication cart. Additionally, the key to the narcotic drawer was present in the lock of the unlocked narcotic drawer. The home's, "Accountability of Medication and Controlled Substances" policy indicates all narcotics will be double locked in the home's medication cart.

Resident #7 is prescribed Phenobarbital 32.4 mg-Take 2 tablets by mouth in the morning and take 3 tablets by mouth at night. On 11/9/22, the medication card for the 8:00 am dose contained 22 pills; however, the home's controlled substance record indicated there are 12 pills present. Also, there were 2 medication cards present for the 8:00 pm dose: 1 medication card contained 30 pills, and the 2nd medication card contained 33 pills; however, the home's

185b - Medication Procedures (continued)

controlled substance record indicated there are 20 pills present.

Plan of Correction

Directed (█) - 12/16/2022)

Medication cart was secured immediately on 11/8/22 after exit interview with state inspectors.

1. On 12/5/2022 all DHS med techs re educated by Administration on 2600.185.b- documentation of staff education will be kept.

During this re education med tech staff were instructed that the DHS med tech on duty each shift is responsible to ensure compliance with 2600.185.b and failure to do so will result in an employee write up.

2. education on 12/5/2022 included proper procedure for counting narcotics and all DHS med tech staff are aware that each pill/capsule should be accounted for, not the number of remaining doses. Administrator / assistant will participate in minimally of one narc count per week for 3 months beginning the week of 12/12/22. Documentation of admin or admin assistant check will be indicated on the Narcotic count sheets.

The root cause for violation of resident #7's incorrect count: med tech staff were counting how many slots in the blister packs were present and documenting that number. Some resident's orders (such as resident #7) are ordered to have more than one tab/capsule per dose, in those cases, more than one tab/cap is packaged in each bubble of the blister pack. During education on 12/5/22 staff was re educated in the proper way to conduct a narc count- documentation of education will be kept.

Full narc count done by admin assistant, █ and DHS med tech █ to ensure accuracy and compliance on 11/11/22.

DIRECTED: Within 72 hours of receipt of the plan of correction: The med tech on duty shall inspect the home daily to ensure all controlled substances are double locked in accordance with the home's procedures. █ 12/16/22

Directed Completion Date: 12/19/2022

Not Implemented (█) - 02/23/2023)

187b - Date/Time of Medication Admin.**27. Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #3 is prescribed Invega Sustenna 234 mg-Inject 1 syringe intramuscularly every month. This medication is being administered by a nurse outside of the home; however, resident #3's November 2022 MAR is documented by staff person B on 11/9/22 at 8:00 am as administering this medication to the resident.

REPEAT VIOLATION: 2/15/2022, et. al.

Plan of Correction

Directed (█) - 12/16/2022)

DHS med techs re educated by Administration on 2600.187.b this education included recording on the MAR and that outside agency administereing resident #3's invega is responsible to document appropriately. documentation of education will be kept.

187b - Date/Time of Medication Admin. (continued)

Ark staff no longer has the availability to sign off on this medication on the resident's MAR. Administrator assistant has contacted outside agency with the request that they ensure sign off upon administering Invega in the future. Administrative / assistant will check resident #3 MAR monthly and [REDACTED] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION [REDACTED] 12/16/22) and to ensure documentation is correct. (DIRECTED: Within 5 calendar days of receipt of the plan of correction: The administrator shall review the MAR's of at least 7 residents per week for one month then monthly thereafter, to ensure all proper medication administration documentation is present on resident MAR's in accordance with 2600.187b [REDACTED] 12/16/22).

Directed Completion Date: 12/20/2022

Not Implemented [REDACTED] - 02/23/2023)

187d - Follow Prescriber's Orders**28. Requirements**

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed blood glucose checks once daily; however, resident #2's blood glucose was not checked on 11/5/22.

Resident #7 is prescribed Divalpro-Ex 500 mg-Take 1 tablet by mouth twice a day; however, on 11/9/22 at 8:00 am, resident #7 was administered Divalpro-EX 250 mg tablet.

REPEAT VIOLATION: 2/15/2022, et. al.

Plan of Correction

Directed ([REDACTED] - 12/16/2022)

DHS med techs re educated by Administration on 12/5/2022. 2 training included 600.187.d- following the directions of the prescriber

Documentation of education will be kept.

Administrator / assistant will check for compliance beginning the week of 12/12/22- minimally of weekly x 2 months. During this check admin / assistant will observe med tech administering medications and confirm all medications are given as ordered by resident's PCP and that glucose checks are being obtained as ordered by MD.

Documentation of checks will be kept.

incident report faxed to DHS on 11-9-2022 while inspectors were on site to report resident #7 medication error. Pharmacy was contacted in regards to packaging and providing medication as ordered- correct dose in received from pharmacy on 11/9/22.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The administrator shall review the medications and medication administration documentation of at least 7 residents per week for one month, then monthly thereafter, to ensure the directions of the prescriber are being followed and all current prescribed medications are present in the home and available for administration. [REDACTED] 12/16/22).

Directed Completion Date: 12/14/2022

187d - Follow Prescriber's Orders (continued)

Not Implemented [redacted] 02/23/2023)

225c - Additional Assessment

29. 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 [redacted]; however, resident #1's previous assessment was completed on 7/12/21.

Resident #3's most recent assessment was completed on [redacted] however, resident #3's previous assessment was completed on 5/24/21.

Resident #13's most recent assessment was completed on [redacted] 2; however, resident #13's previous assessment was completed on 5/5/21.

REPEAT VIOLATION: 7/20/2022; 6/8/2022; 2/15/2022, et. al.; 11/2/2021, et. al.

Plan of Correction

Directed [redacted] - 12/16/2022)

n August 2022, all resident charts were audited by Administration to ensure all assessments were completed per regulation.

Administrator / assistant has produced a calendar to reference when assessments are due for each resident calendar created to begin December 2022 and will be maintained/ updated by admin / assistance monthly. Administrator / assistant will refer to this calendar monthly to ensure compliance with 2600.225.c (DIRECTED: Within 48 hours of receipt of the plan of correction: The calendar shall be reviewed by the administrator weekly for 3 months, then monthly thereafter, to ensure the calendar is current and to ensure an assessment is completed for each resident, at east annually. [redacted] 12/16/22).

Admin / assistant re educated on 2600.225.c on 12/12/22 documentation will be kept.

Directed Completion Date: 12/18/2022

Not Implemented [redacted] - 02/23/2023)

Department of Human Services
Bureau of Human Service Licensing
PRIVACY CODING

Facility Information

Name: ARK MANOR License #: 44686 License Expiration: 02/10/2023
Address: 105 SANDRA DRIVE, DELMONT, PA 15626

Inspection Information

Start Date: 11/08/2022 Type: Full

Staff Privacy Coding

<u>Designation</u>	<u>Staff Member Name</u>	<u>Job Title</u>	<u>Date Hired</u>
Staff Member A	Breanna Oravitz		
Staff Member B	Kristen Morford		

Resident Privacy Coding

<u>Designation</u>	<u>Resident's Name</u>
Resident 1	Clara Oslosky
Resident 2	Kenneth Dean
Resident 3	David Spielman
Resident 4	Michael Culliver
Resident 5	Terrance Hartsfield
Resident 6	Larry Barnett
Resident 7	Millicent Griffith
Resident 8	Everett Johnson
Resident 9	Gustave Malmquist
Resident 10	Robert Bowman
Resident 11	William Artz
Resident 12	Frank Grback
Resident 13	Michelle Flemm
Resident 14	Gilbert Oravetz

A license will not be issued to your facility unless it complies with the following statutes and regulations that prohibit discrimination based on race, color, religious creed, disability, ancestry, national origin, age, or sex:

- a. The Pennsylvania Human Relations Act (43 P.S. §§ 951-962.2).
- b. The Age Discrimination Act of 1975 (42 U.S.C.A. §§ 6101-6017).
- c. Title VI of the Civil Rights Act of 1964 (42 U.S.C.A. §§2000d-2000d-4), if applicable.
- d. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. § 794), if applicable.
- e. Title VII of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000e-2000e-17), if applicable.

To satisfy this requirement, please complete the following information in its entirety. Please be sure to either type or print clearly. Be sure to include a valid email address on your Attestation. If additional space is required for any of the required answers, please attach a separate 8 1/2" x 11" sheet to complete answers. Please denote license number (if applicable) on additional sheets. Be sure to number your corresponding answer.

BEFORE YOU SUBMIT YOUR APPLICATION:

- Is the Attestation completed in its entirety?
- Have you provided a valid email address?
- If you have multiple locations, has each location and certificate/license number been listed on the form? (Question 2)
- If you have updated and/or changed documentation submitted with your original CRC Form, are the revised documents included? (Question 4)

DHS CIVIL RIGHTS COMPLIANCE ATTESTATION

1) I Ben Wilner, CEO, am the person responsible for the legal entity of Ark Manor ("facility"). I understand that a Certificate of Compliance will not be granted unless there has been compliance with civil rights laws and applicable regulations pursuant to 55 Pa. Code 20.36 and 55 Pa. Code Appendix A ("civil rights laws").

2) The facility is located at 105 Sandra Drive Delmont, PA 15626 and the certificate license number is 44686. Contact email for this facility is: arkmanorpch@gmail.com. If the facility has multiple locations, please complete 2a.

a. Additional Location(s)	Certificate/License Number
<u>[Location 2]</u>	<u>[Certificate Number 2]</u>
<u>[Location 3]</u>	<u>[Certificate Number 3]</u>

If you have additional locations, please add an attachment with location and certificate/license number.

3) The facility is a Personal Care Home (example such as personal care home, child day care, office) and offers the following types of services/admissions/referrals:
Personal Care Services

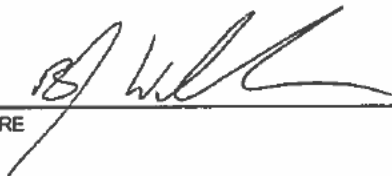
4) The facility's compliance with civil rights law was verified by the Department at the time that the last license was issued. The facility previously submitted all required documentation, including policies and procedures and the facility's non-discrimination policy statements. Since that time (check one):

- The facility has NOT changed and/or updated the documents, referenced above in Question 4, submitted to the Department.
- The facility HAS changed or updated the documents, referenced above in Question 4, submitted to the Department. Changed and/or updated documents are included with this Attestation.

- 5) The facility affirms that it has developed and maintains a "Non-Discrimination in Services" policy statement for services, referrals, and/or admissions and a "Non-Discrimination in Employment" policy statement, signed by the person responsible for the legal entity, that advises clients/residents/parents/guardians, the public and employees of the following:
- a. That services, referrals, admissions, and employment are provided in a non-discriminatory manner, without regard to race, sex, color, national origin (address issue of Limited English Proficiency, in the service policy only), ancestry, religious creed, disability, and age.
 - b. That reasonable physical accommodations and program accessibility to staff or clients with physical disabilities will be provided such that:
 - i. The facility's restrooms, drinking fountains, and any other human needs facilities are accessible to clients/residents/parents/employees/visitors with disabilities;
 - ii. If the facility serves non-English speaking clients, it provides meaningful access to its programs and services. (Meaningful access involves some combination of services for oral interpretation and written translation of vital documents)
 - iii. The facility has a policy to integrate minorities, persons with disabilities, and/or individuals with Limited English Proficiency into programs and activities; and
 - iv. The facility's non-discrimination policy states that reasonable accommodation will be provided for individuals with a physical disability (e.g. hearing, speech, vision, mobility impairments).
 - c. The procedure by which staff and clients can file complaints alleging discrimination and have their complaints investigated and resolved objectively, which includes the name of the person assigned to investigate the complaint.
 - i. The facility informs clients, residents, parents/guardians that complaints of discrimination may be filed with the U.S. Department of Health and Human Services' Office of Civil Rights (OCR), the DHS Bureau of Equal Opportunity (BEO) and/or the Pennsylvania Human Relations Commission (PHRC).
 - ii. The facility informs its employees regarding their rights to file complaints of employment discrimination based on Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, and/or the Pennsylvania Human Relations Act of 1955, as amended, with the PHRC or Equal Employment Opportunity Commission (EEOC).
- 6) Within the last 12 months, the facility (check one): HAS HAS NOT had any complaints of discrimination filed against it with PHRC, BEO, EEOC, or OCR.
- 7) The facility agrees to provide a copy of its non-discrimination policies upon request pursuant to 62 P.S. § 1016 (relating to right to enter and inspect) and 55 Pa. Code § 20.34 (relating to access.).
- 8) The facility will comply with the following statutes and regulations that prohibit discrimination based on race, color, religious creed, disability, ancestry, national origin, age or sex:
- a. The Pennsylvania Human Relations Act (43 P.S. §§ 951-962.2).
 - b. The Age Discrimination Act of 1975 (42 U.S.C.A. §§ 6101-6017).
 - c. Title VI of the Civil Rights Act of 1964 (42 U.S.C.A. §§ 2000d-2000d-4), if applicable.
 - d. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. § 794), if applicable.
 - e. Title VII of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000e-2000e-17), if applicable.

I declare, under penalty of perjury, pursuant to 18 Pa. C.S. § 4904(a) (relating to unsworn falsification to authorities), that the foregoing averments are true and correct, to the best of my knowledge, information, and belief. I understand the penalty for unsworn falsification to authorities is a misdemeanor of the second or third degree, and I can be penalized by fine, imprisonment, or a combination of these for making any false statements in this attestation. I understand that submitting false information on this attestation may also subject me to licensing action up to and including license revocation and/or emergency removal of clients/residents.

Ben Willner, CEO
 RESPONSIBLE OFFICIAL NAME/TITLE (PRINT)


 SIGNATURE

10-18-22
 DATE

I will retain copies of all forms and documentation submitted to the Department.

RECOMMENDATION FOR CERTIFICATE OF COMPLIANCE (RENEWALS ONLY)



INSTRUCTIONS: Regional Program Office completes form, makes two copies, keeps one copy and forwards the original and one copy to the Licensing Office. (This form is to be used for RENEWALS ONLY.)

REGION WESTERN		COUNTY WESTMORELAND	
NAME AND ADDRESS OF AGENCY/FACILITY ARK MANOR		FACILITY E-MAIL	
105 SANDRA DRIVE DELMONT 15626			
MAILING ADDRESS OF FACILITY 105 SANDRA DRIVE DELMONT PA 15626		LEGAL E-MAIL BWILLNER@WHITESTONEHC.COM	
		TELEPHONE NO.: 724-468-6200	
NAME OF LEGAL ENTITY ARK MANOR LLC		FEIN/SSN:	
CURRENT CERTIFICATE NUMBER 446861	TYPE OF CONTROL <input type="checkbox"/> PUBLIC <input checked="" type="checkbox"/> PRIVATE		
EFFECTIVE DATE FROM 08/10/2022 TO 02/10/2023	IF PRIVATE <input checked="" type="checkbox"/> PROFIT <input type="checkbox"/> NON-PROFIT		

TYPE OF FACILITY & TYPE OF SERVICE PROVIDED:	
ADULT RESIDENTIAL FACILITIES PERSONAL CARE HOMES SSI: 16 Per Jeanne Parisi on 3/10/23, after reviewing with Jamie Buchenauer, resubmit for Provisional due to progress made by home with appeal sent to Lestia Fetzer. 60+: 28 MI: 16 ID: 4 MN: 3 RCVD 3.14.23	
DATE(S) OF INSPECTION	8/29/22; 11/8/22; 11/9/22; 11/10/22

RECOMMENDATIONS:			
<input checked="" type="checkbox"/> CERTIFICATE RECOMMENDED	TYPE <input type="checkbox"/> REGULAR <input checked="" type="checkbox"/> PROVISIONAL	IF PROVISIONAL <input type="checkbox"/> FIRST <input checked="" type="checkbox"/> SECOND <input type="checkbox"/> THIRD <input type="checkbox"/> FOURTH	
		SCORE	PERIOD 6 Months-effective date of issuance FROM 3.17.23 TO 9.17.23
<input checked="" type="checkbox"/> CERTIFICATE NOT RECOMMENDED	REASON <input type="checkbox"/> DENIAL <input checked="" type="checkbox"/> NON-RENEWAL <input type="checkbox"/> REVOCATION <input type="checkbox"/> VOLUNTARY CLOSURE <input type="checkbox"/> OTHER		
LIST REGULATION CHAPTER Chapter 2600		FIRE SAFETY APPROVAL <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
		DATE 6/23/06	TYPE C2/LP
		LICENSED CAPACITY 70	CURRENT CENSUS 33

LIST ANY RESTRICTIONS TO OCCUPANCY OR WAIVERS OF REGULATION

 2/23/23 _____ SIGNATURE – PERSON MAKING RECOMMENDATION	 2/27/2023 _____ APPROVED BY
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Event/Incident Reporting Form

1. **Date of Event:** 11/10/2022
2. **Provider Type:** **Personal Care Home**
3. **Number Served:** **70 Capacity; 33 Number Served (16 SSI; 28 60+; 16 MI; 4 ID; 3 MN).**
4. **County where event occurred:** **Westmoreland**

5. **Provider History:**

1st Provisional License: August 10, 2022 – February 10, 2023

Multiple and repeat violations to include unsafe devices, indoor temperatures, unsanitary conditions, incomplete support plans, failure to report abuse, to AAA and the Department, Abuse, furniture and equipment in disrepair, unlocked and accessible medications, failure to update assessments. Failure to suspend or place staff accused of abuse on a plan of supervision, failure to maintain resident record confidentially, failure to obtain contract signatures, failure to treat residents with dignity and respect, disposing of resident belongings, late criminal history background checks, inadequate staffing levels, failure to provide initial staff training, failure to provide 40 hour staff training, uncovered trash inside the home, excessive water standing in the basement, excessive hot water temperatures, dirty bed linen, undated food, unsealed food, failure to return resident laundry, portable space heaters used in the home, incomplete medical evaluations, failure to follow prescribers orders, incomplete and failure to update support plans, no soap in bathrooms, unlocked and accessible medications, unaccountability of medications, uncalibrated glucometers, staff not administering medication signing the MAR, failure to assist residents with keeping clothing clean, no clean linen, no toilet paper in bathrooms, unqualified direct care staff, direct care staff without training, inoperable fire alarm system, inaccessible support plans, and incomplete resident records.

Regular License: February 19, 2022 – February 19, 2023

Regular License: February 19, 2020 – February 19, 2021

6. **Description of Event:**

Inspections conducted on August 29, 2022, and November 8, 9 and 10, 2022, found multiple serious and repeated violations. The uncorrected violations included several unsanitary conditions, infestation of flies, undated batteries in carbon monoxide detectors, failure to provide quarterly financial statements to residents and their designated persons, failure to conduct a complete quality management review within the past year, an untimely Pennsylvania criminal history background check, untimely completion of direct care competency test, sharing of glucometers, failure to maintain exterior trash in covered receptacles, inoperable bathroom exhaust fan, numerous surfaces in disrepair, construction materials present throughout a wing of the home, inoperable outdoor lighting, no bedside lighting, failure to maintain safe food storage temperatures, a chair wedged under an exit door on the outside of the home, failure to repair the home's inoperative fire system within 48 hours, failure to conduct fire

Event/Incident Reporting Form

watches while the fire system was inoperable, failure to alternate exits during fire drills, incomplete and untimely medical evaluations, unlocked and unattended medications, medications not available in the home for administration, inaccurate and incomplete blood sugar documentation for numerous residents, failure to follow procedures for the accountability and administration of controlled substances, inaccurate medication administration documentation, failure to follow prescribers' orders and untimely annual assessments.

7. Action:

2nd Provisional License - 6 Months

8. Next Steps:

BHSL will conduct a fines inspection within 20 days of license issuance and attempt to commence a full renewal inspection at least 3 months in advance of expiration.

9. Basis for Action:

Serious and repeated violations and failures to develop and implement plans of correction.

10. Shared Communication:

The operator, based out of New Jersey, operates multiple other personal care homes in the region including Hillside Manor (1st Provisional), and regular licenses at Country Manor, Latrobe Manor, and Melody Manor.