

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

January 26, 2023

[REDACTED]
UMH PA CORP
50 WEST TIOGA STREET
TUNKHANNOCK, PA, 18657

RE: TUNKHANNOCK MANOR
50 WEST TIOGA STREET
TUNKHANNOCK, PA, 18657
LICENSE/COC#: 23655

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/22/2022, 11/29/2022 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: TUNKHANNOCK MANOR License #: 23655 License Expiration: 12/08/2023
 Address: 50 WEST TIOGA STREET, TUNKHANNOCK, PA 18657
 County: WYOMING Region: NORTHEAST

Administrator

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

Legal Entity

Name: UMH PA CORP
 Address: 50 WEST TIOGA STREET, TUNKHANNOCK, PA, 18657
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I 2 Date: 06/23/2015 Issued By: L&I
 Type: C 2 LP Date: 07/26/1991 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 23 Waking Staff: 17

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Incident Exit Conference Date: 12/09/2022

Inspection Dates and Department Representative

11/22/2022 On Site [REDACTED]
 11/29/2022 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 42 Residents Served: 23
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 23
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

11/22/2022 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/22/2022

Inspections / Reviews *(continued)*

01/08/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/13/2023

01/26/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

17 - Record Confidentiality

1. 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 11/22/22, when Department representative went to Med room, there was no staff present and the door was unlocked. 2 med carts in the room were unlocked.

Repeat Violation 9/28/21

Plan of Correction

Accept [REDACTED] - 01/08/2023)

Upon discovery that the medication carts and medication storage room were unlocked, each was immediately locked. On-site staff members responsible for medication administration and/or who had access to the medication storage room were immediately re-educated regarding the requirements that the medication storage room must be kept locked when a staff member is not present in the room and that the medication carts must be locked when staff are not utilizing the medication cart.

Completion date: 11/22/22

All nurses and PCAs were re-educated regarding the requirements that the medication storage room must be kept locked when a staff member is not present in the room and that the medication carts must be locked when staff are not utilizing the medication cart.

Completion date: 11/23/22

The shift supervisor will conduct daily audits to ensure medication storage rooms and medication carts are locked in compliance with requirements for 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [REDACTED] - 01/23/2023)

20b6 - Interest Bearing Account

2. Requirements

2600.

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

- 6. If a home is holding more than \$200 for a resident for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

Description of Violation

The home held money for resident #1, from 7/1/22 to 9/30/22, during which time the balance of those funds did not fall below [REDACTED]. The home has not offered an interest-bearing account. The home also held money for resident #2, from 6/17/22 to 9/30/22, during which time the balance of those funds did not fall below \$ [REDACTED]. The home has not offered an interest-bearing account.

Plan of Correction

Accept [REDACTED] - 01/08/2023)

Resident #1 and Resident #2 were provided written notice of the facility's obligation to notify the resident and offer

20b6 - Interest Bearing Account (continued)

him/her assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution.

Completion date: 11/22/2022

All residents for whom the Homes has been holding more than \$200 for more than two consecutive months were provided written notice of the facility's obligation to notify them and offer assistance in establishing an interest-bearing account in their name at a local Federally-insured financial institution.

Completion date: 11/25/2022

The administrative assistant was re-educated regarding the facility's obligation to notify residents of their right to establish an interest-bearing account in their name at a local Federally-insured financial institution if the Home holds more than \$200 of their funds for more than two consecutive months in addition to the Home's responsibility to provide assistance in the establishment of such accounts.

Completion date: 11/23/2022

The administrator or designee will conduct monthly audits to monitor compliance with this regulatory requirement for the next 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented (████) - 01/23/2023)

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

The resident-home contract, dated █████/20, for resident #3, was not signed by the resident.

The resident-home contract, dated █████/22, for resident #4 was not signed by the resident. The resident-home contract, dated █████, 20, for resident #5 was not signed by the resident.

Plan of Correction

Accept (████) 01/08/2023)

The facility's Administrator and Administrative Assistant were re-educated on 11/23/2022. The Administrator is conducting an audit of resident contracts for future compliance with regulation 25.b.

Completion Date: 01/23/2022

The Administrator / designee will monitor/ensure ongoing compliance with all new incoming residents and audit monthly for 6 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented (████) - 01/23/2023)

41e - Signed Statement**4. Requirements**

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

41e - Signed Statement (continued)

Description of Violation

Resident #3, #4, and #5's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Accept [redacted] - 01/08/2023)

Signed statements acknowledging receipt of the Homes resident's rights and complaint procedures were obtained from residents #3, #4, and #5 and copies added to residents' records.

Completion date: 11/23/2022

100% of current resident records will be reviewed to ensure copies of signed acknowledgement statements were present.

Completion date: 01/23/2023

The administrator and administrative assistant were re-educated regarding the regulatory requirement to ensure a copy of the signed statement acknowledging receipt of the Homes resident's rights and complaint procedures is present in each resident's record.

Completion date: 11/23/2022

The administrator or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [redacted] - 01/23/2023)

42b Abuse

5. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Interviews with Staff E, F, and G verified that resident #9 had a history of elopement and exit seeking behaviors.

[redacted] On [redacted] /22, Resident #9 eloped from home. According to the security company, the door the resident eloped from, the audible was not working properly and staff did not know immediately when the resident left the home. [redacted]

Plan of Correction

Accept [redacted] 01/08/2023)

On the date of the elopement, all Home exit doors were inspected by the security company. The volume of the audible alarm in the door used by the resident to elope was increased.

Completion date: 09/22/22.

Resident #9 was discharged from the facility.

42b - Abuse (continued)

The facility staff were re-educated on the elopement policy.

Completion date: 09/23/22.

The administrator or designee will check exit door audible alarms to ensure each is set to the volume recommended by the alarm manufacturer on a weekly basis.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [REDACTED] - 01/23/2023)

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 D was hired on [REDACTED]/21. Staff D was rehired with less than 1 year lap in service. Staff D's Criminal record check indicated that the request was under review. No follow up documentation was available at time of inspection.

Plan of Correction

Accept [REDACTED] - 01/08/2023)

Direct Care Staff D's completed criminal record check document was obtained, reviewed, and added to the staff member's HR file. Completion date: 11/22/22.

100% of direct care staff HR files were audited to ensure each had a criminal record check on file and that each were in compliance with all regulatory requirements.

Completion date: 11/30/2022.

The Administrator was re-educated regarding criminal history record check regulatory requirements.

Completion date: 11/22/22.

The administrator or designee will conduct monthly audits to monitor compliance with this regulatory requirement for the next 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [REDACTED] - 01/23/2023)

54a - Direct Care Staff**7. Requirements**

2600.

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

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

54a - Direct Care Staff (continued)

Description of Violation

Direct care staff person A was hired on [REDACTED] 22. The home did not have documentation that staff person A has a GED, high school diploma or active registry status on the Pennsylvania nurse aide registry. Staff person A provides direct care.

Plan of Correction

Accept [REDACTED] 01/08/2023)

Direct Care Staff A's high school diploma was obtained and added to the staff member's HR file.

Completion date: 11/22/22.

100% of direct care staff files were audited to ensure every Direct Care Staff member has proof of a high school diploma, GED or active status on the Pennsylvania nurse aide registry in their file.

Completion date: 11/30/2022

The administrator was re-educated regarding the requirement that a direct-care staff person hired after November 10, 2005 must have a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aide registry and that documentation of such must be maintained in the staff person's HR file.

Completion date: 11/23/22.

The administrator or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [REDACTED] - 01/23/2023)

65a - FS Orientation 1st Day

8. Requirements

2600.

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

Description of Violation

Direct care staff person D, whose first day of work was [REDACTED] 21, did not receive orientation on training topics #1 through 7.

Plan of Correction

Accept [REDACTED] - 01/08/2023)

n-service training for topics #1-7 was completed by Staff Person D.

Completion date: 11/23/22.

The Home audited training records and ensure all current staff are educated on training topics #1-7.

Completion date: 11/25/2022

The administrator and the administrative assistant were re-educated regarding the requirement that, prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and olunteers shall have an orientation in general fire safety and emergency preparedness.

Completion date: 11/23/2022

The administrator or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

65a - FS Orientation 1st Day (continued)

Implemented (████) 01/23/2023)

65b - Rights/Abuse 40 Hours

9. Requirements

2600.

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

Description of Violation

Direct Care Staff Person D completed █████ 40th scheduled work hour during week of █████ 21. However, this staff person did not complete training in topics #1 through 4.

Repeat Violation 9/28/21

Plan of Correction

Accept (████) - 01/08/2023)

n-service training for topics #1-4 was completed by Staff Person D.

Completion date: 11/23/22.

The facility will audit training records and ensure all current staff are educated on training topics #1-4.

Completion date: 11/25/2022.

The administrator and the administrative assistant were re-educated regarding the requirement that all direct care staff persons, ancillary staff persons, substitute personnel and volunteers have an orientation that includes all topics all topics outlined in 2600.65(b) within 40 scheduled working hours.

Completion date: 11/23/22.

The administrator or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented (████) - 01/23/2023)

103i - Outdated Food

10. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The freezer in the dry storage area had a quart container of Tortilla Soup that was not dated.

Plan of Correction

Accept (████) - 01/08/2023)

The tortilla soup was disposed of.

Completion date: 11/22/2022

Contents of the freezer were examined. No other undated items were identified.

Completion date: 11/22/2022

103i - Outdated Food (continued)

Dietary staff were re-educated regarding the requirement to ensure that all freezer contents are labeled with the date the item was placed in the freezer.

Completion date: 11/23/22.

The dining manager or designee will conduct weekly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented (████) - 01/23/2023)

132b Safety Inspection/Fire Drill**11. Requirements**

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection was complete on 7/21/19. The home did not have documentation that a fire safety inspection was conducted by a fire safety expert within the past 12 months.

Plan of Correction

Accept (████) 01/08/2023)

The annual fire safety inspection and fire drill was conducted by a fire safety expert. Documentation of this fire drill and fire safety inspection is on file at the Home.

Completion date: 11/30/22.

The administrator was re-educated regarding the requirement to have a fire safety inspection and fire drill conducted by a fire safety expert annually along with the requirement to maintain documentation of this fire drill and fire safety inspection.

Completion date: 11/23/2022

The administrator will conduct an audit to monitor compliance with this regulatory requirement annually.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented (████) - 01/23/2023)

132d - Evacuation**12. Requirements**

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The fire drills that were held between December 2021 and October 2022 exceeded 2 minutes and 30 seconds. The

132d - Evacuation (continued)

home does not have a current annual fire safety expert recommendation to extend their evacuation time.

Plan of Correction

Accept [redacted] 01/08/2023)

The annual fire safety inspection and fire drill documentation, completed by a fire safety expert, includes an amended evacuation time of 4 minutes and 30 seconds.

Completion date: 11/30/22

The administrator was re-educated regarding the requirement that evacuations be completed within the current timeframe recommended by the fire safety expert.

The administrator will conduct annual audit to monitor compliance with this regulatory requirement.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [redacted] - 01/23/2023)

185a - Implement Storage Procedures

13. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #6's glucometer was not calibrated to the correct time.

Plan of Correction

Accept [redacted] - 01/08/2023)

Resident #6's glucometer was calibrated to the correct time.

Completion date: 11/22/2023

All other glucometers in use were evaluated and, if needed, recalibrated to ensure each was calibrated to the correct time.

Completion date:11/22/2022

Licensed staff and PCAs were re-educated regarding the requirement to ensure that all glucometers are calibrated to the correct time.

Completion date: 11/22/22.

The LPN Supervisor or designee will conduct weekly audits to ensure that all glucometers are calibrated to the correct time for 6 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [redacted] 01/23/2023)

227d Support Plan Medical/Dental

14. 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.

227d - Support Plan Medical/Dental (continued)

Description of Violation

A Nurse is on duty during the day until 3:00pm. Resident #8 is prescribed [redacted] injection (IM) [redacted]. The homes policy is that only a nurse can administer IM injections. The Assessment and support plan do not address what action will be taken if a nurse is not on duty at the time the medication needs to be administered.

Staff D, E, and F stated that Resident #9 is on enhanced checks. However, the Assessment and support plan does not address these additional checks or what the home is doing to ensure residents safety.

Plan of Correction

Accept [redacted] - 01/08/2023)

Resident #8's physician was contacted. The physician changed this medication to one this is not IM.

Completion date: 11/23/2022.

100% of current resident medication orders were reviewed. No other medication orders with the intramuscular (IM) administration route were identified.

Completion date: 11/23/2022.

Nursing staff who transcribe medical practitioner orders were re-educated on facility policy that only licensed staff may administer medications via the intramuscular route and that, when an IM medication is ordered, providers should be consulted to obtain an alternative to the IM medication to be administered when a licensed nurse is not on-site.

Completion date: 11/23/2022

The LPN Supervisor or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter.

100% of current resident records were reviewed. [redacted]

Completion date: 11/23/2022

The LPN Supervisor was re-educated regarding the requirement to ensure each resident's Resident Assessment and Support Plan (RASP) address enhanced checks or other interventions when required to help maintain the resident's safety.

Completion date: 11/23/22.

The administration or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented ([redacted] - 01/23/2023)

252 - Record Content

15. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

- 3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #3's picture was dated [redacted] 20 and Resident #7's picture was dated [redacted] /20.

252 - Record Content (continued)

Plan of Correction**Accept (MM 01/08/2023)**

An updated photograph of Residents #3 and #7 were obtained and added to the respective resident's record.

Completion date: 12/05/22.

An updated photograph of all other facility residents were obtained and added to each respective resident's record.

Completion date: 12/5,12/7/2022.

The administrative assistant was re-educated o the requirement's of regulation 2600.252.

The administrator or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 6 months and as needed thereafter.

Licensee's Proposed Overall Completion Date: 01/23/2023

Implemented [REDACTED] - 01/23/2023)