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

January 25, 2023

APRONTREE PERSONAL CARE LLC
18015 PATH VALLEY ROAD
SPRING RUN, PA, 17262

RE: APRONTREE PERSONAL CARE
18015 PATH VALLEY ROAD
SPRING RUN, PA, 17262
LICENSE/COC#: 33449

Dear

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

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *APRONTREE PERSONAL CARE* **License #**: *33449* **License Expiration**: *11/08/2023*

Address: *18015 PATH VALLEY ROAD, SPRING RUN, PA 17262*

County: *FRANKLIN* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *APRONTREE PERSONAL CARE LLC*

Address: *18015 PATH VALLEY ROAD, SPRING RUN, PA, 17262*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *08/21/1985* **Issued By**: *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *11/22/2022*

Inspection Dates and Department Representative

11/22/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *21* **Residents Served**: *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *11* **Are 60 Years of Age or Older**: *13*

Diagnosed with Mental Illness: *14* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

11/22/2022 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/10/2022*

12/15/2022 - POC Submission

Submitted By: **Date Submitted**: *01/06/2023*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/22/2022*

Inspections / Reviews *(continued)*

12/27/2022 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/06/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *01/03/2023*

01/25/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *01/06/2023*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home's boiler certificate expired on 2/14/22.

Plan of Correction ***Accept (- 12/22/2022)***

The Boiler was inspected on 02/25/2022 with a certificate expiration date of 2/10/2024. The Department of Labor and Industry failed to send an invoice/certificate. It was an oversite that the certificate was not received. The Department of Labor and Industry was notified immediately upon discovery on 11/22/2022 by staff member designated by administrator. It was confirmed on 11/22/2022 that the inspection had been done and the invoice/current certificate was emailed to the administrator by the Dept of Labor and Industry on 11/23/2022 who printed and filed the certificate. To avoid the oversite in the future the administrator will review all certificates monthly to make sure that all updated certificates have been received and printed. The monthly checks by the administrator will begin January 1 2023. The folder that houses the certificates such as the Boiler Certificate, Compliance Certificate, Water Certificate, Fire Reports, and Agency Reports is what will be reviewed by the administrator monthly. This will also assist in making sure that other current certificates have been received and not expired.

Licensee's Proposed Overall Completion Date: *12/21/2022*

Implemented (- 01/20/2023)

65a - FS Orientation 1st Day

2. 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

Staff Member A whose first date of work is /22, did not receive orientation on the following topics:

1. Evacuation procedures

2. Staff duties & responsibilities -fire drills

3. Designated meeting place outside/interior fire safe area

4. Smoking safety procedures/policy

5. Location & use of fire extinguishers

6. Smoke detectors & fire alarms

7.Telephone use and notification of emergency services

Plan of Correction ***Directed - 12/23/2022)***

The above stated employee (cook) as all employees have been trained in the above areas during orientation. The administrator failed to have employee sign sheet acknowledging said training/orientation. The administrator had the said employee sign the acknowledgment sheet on 11/23/22, stating the above training had been completed during orientation period. Staff member (cook) oriented new staff member on first day of work 7/16. A

65a - FS Orientation 1st Day (continued)

checklist has been added to employee's file by the administrator on 11/23/22 and was implemented on that date. The administrator will review all new employee records upon hire and date when the required items are added/completed. The checklist includes Background check, orientation/training records (evacuation procedures, staff duties and responsibilities, fire drill procedure, smoking policy, location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services), W4 form, application, proof of residency, education documentation.

Directed

- *On 11/23/22 Staff Member A signed the acknowledgement sheet indicating orientation was originally completed on 7/16/22.*
- *On 11/23/22 the administrator added a checklist, to the staff member's record to include the background check, orientation/training records (evacuation procedures, staff duties and responsibilities, fire drill procedure, smoking policy, location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services).*
- *Beginning 1/3/22, the administrator will audit all current staff records using the checklist.*
- *Beginning 11/23/22, the administrator will review all new employee records upon hire and date when the required items are added/completed.*

Directed Completion Date: *12/22/2022*

Implemented [redacted] - 01/23/2023)

65b - Rights/Abuse 40 Hours

3. 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

Staff Member A whose first date of work is [redacted]/22, did not receive Rights/Abuse 40 Hours in the following topics:
1. Resident rights
2. Emergency medical plan
3. Mandatory reporting of abuse - OAPSA
4. Reporting reportable incidents and conditions

Plan of Correction ***Directed ([redacted] - 12/23/2022)***

The same staff member as mentioned above was trained during [redacted] orientation period but the administrator failed to include [redacted] signed sheet in the employee's file. The employee had been trained by the administrator on 7/22/22 in the areas of Resident rights, Emergency Medical Plan, Mandatory reporting of abuse and reportable incidents and conditions. The administrator had the employee sign the training sheet indicating as such and it was added to the employee's file on 11/23/22. A new employee checklist was added to the employee's file on 11/23/22 by the administrator. The checklist includes Background check, W4 form, application, proof of residency, education documentation, and orientation/training records (including resident rights, Emergency medical plan, mandatory reporting of abuse, reporting of reportable incidents and conditions). The administrator had all cooks including

65b - Rights/Abuse 40 Hours (continued)

the mentioned employee complete the updated online Mandatory Abuse Reporting Training Course which was completed on 12/1/22. The cooks had not completed the on-line abuse training course. It will be the responsibility of the administrator to complete the checklist and review all new employee records to make sure all mandatory documentation has been received. This checklist was added by the administrator to all current employee records.

Directed

- *On 11/23/22 Staff Member A signed the acknowledgement sheet indicating training was originally completed on 7/22/22.*
- *On 11/23/22 the administrator added a checklist, to the staff member's record to include the background check, orientation/training records (evacuation procedures, staff duties and responsibilities, fire drill procedure, smoking policy, location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services).*
- *Beginning 1/3/22, the administrator will audit all current staff records using the checklist.*
- *Beginning 11/23/22, the administrator will review all new employee records upon hire and date when the required items are added/completed.*

Directed Completion Date: *12/22/2022*

Implemented [redacted] - 01/23/2023)

88a - Surfaces

4. 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 11/22/22 at 10:34am, the following items were observed on the front porch area: several pieces of plywood, an accumulation of dry leaves, a glass aquarium, a door, an electric fan, two 1- gallon water jugs, a section of wire fence.

On 11/22/22 at 10:34am, an accumulation of dry leaves was observed outside the back exit door closest to the basement door.

Plan of Correction ***Directed [redacted] 12/23/2022)***

The items were removed from the front porch area by direct care staff person on 11/23/22. All leaves were removed (both front porch and back door areas) on 11/23/22 by same direct care staff person. Staff were reminded via communication log written by administrator on 11/23/22 to address the entire porch area when sweeping/cleaning. Materials used during remodeling will not be temporarily stored on the porch. Action was taken immediately to rectify the situation by direct care staff and the administrator. It is the responsibility of direct care staff to clear the front porch and to ensure the doors are clear from any leaves or debris. The administrator will observe porch area is clear and all doors are free from debris upon entry into the building.

Directed

- *On 11/23/22, all items noted in violation were removed from the porch area by the Direct Care Staff Person.*

88a - Surfaces (continued)

- *On 11/23/22, all leaves were removed from the front porch and back door areas by the Direct Care Staff Person.*
- *On 11/23/22, the administrator reminded all staff via written communication log to address the entire porch area when sweeping and cleaning.*
- *Beginning 11/23/22, the administrator will ensure any material used during remodeling or otherwise will not be temporarily stored on the porch or the surrounding area*
- *Beginning 11/23/22 the administrator will observe the porch and back door areas weekly to ensure the areas remains clear and free from debris.*
- *The Administrator will develop a checklist by 1/3/23 to document the results and findings.*

88a - Surfaces (continued)

Directed Completion Date: *12/22/2022*

Implemented (NN - 01/23/2023)

95 - Furniture and Equipment

5. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 11/22/22 at 11:00am the fire panel screen was observed showing the date 3/22/2009 and the time 14:48:26.

Plan of Correction ***Accept [redacted] - 12/23/2022)***

NAC (National Alarm Company) was contacted by direct care staff member on 11/22/22 in regards to the incorrect date on the fire panel screen. We are not able to program that equipment. They were to have a representative contact us. No contact was made so on 12/1 they were contacted by the administrator. They were not able to send a serviceman out until 12/12/22 to correct and program the correct date/time. The administrator added the fire panel to the routine checklist where currently the dryer vent, emergency lights, dryer plug, and fire extinguishers monthly checks are documented on 12/1. On 12/1/22 when completing the checklist, the administrator noted that the incorrect time was displayed and the company was contacted and coming to service on 12/12/22. On 12/12 the serviceman corrected the date and time. The correction was noted on the checklist by the administrator. The direct care staff member that has been designated to perform these monthly checks was verbally made aware by the

95 - Furniture and Equipment (continued)

administrator that the fire panel would now be included and documented on the existing checklist. The updated checklist was reviewed by the administrator and designated direct care staff employee.

Licensee's Proposed Overall Completion Date: *12/22/2022*

Implemented (01/23/2023)

103i - Outdated Food

6. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 11/22/22 at 10:42am, several packages of ground beef were observed in the kelvinator freezer, these packages were not labeled with a date.

Plan of Correction ***Directed (- 12/23/2022)***

This freezer had fresh ground meet added on 11/17/22 in individual one pound bags. The freezer was never labeled with the date. Upon discovery on 11/22/22 the administrator immediately dated the beef and labeled the freezer. The administrator held a meeting with the cooks 11/23/22 to remind of the importance of labeling and to remove any unlabeled food item if it is found. The cooks are responsible to check food items in the refrigerator daily and to report if something had been missed being dated. A reminder has been posted by the administrator in the kitchen. All food items when brought into the facility are marked by the cooks and checked by the administrator before storing. When fresh ground meat is purchased and packed to be frozen it will be the administrator's responsibility to label the products.

Directed

- *On 11/22/22, the administrator dated the ground beef and labeled the freezer*
- *On 11/23/22, the administrator held a meeting with the cook staff to remind them of the importance of labeling and to remove unlabeled food*
- *Beginning 11/23/22, the administrator posted a reminder in the kitchen to label and date food items*
- *Beginning 11/23/22, when food items are brought into the facility the Cook Staff will ensure foods are labeled with a date.*
- *Beginning 11/23/22, the administrator will be responsible for labeling and dating the ground meats.*
- *Beginning 11/23/22, the administrator will develop a checklist to be used to complete monthly audits of food items, to ensure food items are labeled with a date.*

Directed Completion Date: *12/22/2022*

Implemented (- 01/23/2023)

121a - Unobstructed Egress

7. 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 11/22/22 at 10:32am the gate used to exit the home's front porch toward the rear of the home was blocked by

121a - Unobstructed Egress (continued)

large rock.

Plan of Correction ***Directed (NN - 12/23/2022)***

A resident had moved a rock to hold the above mentioned gait open. The rock was immediately removed by the direct care staff employee when discovered on 11/22/22. The administrator inspected area to remove any objects that could potentially be used to block gait and removed from premises 11/22/22. The residents were educated by the administrator on the dangers of blocking exits and the need to report to a staff member any potential hazards in the future during a town meeting on 12/1/22. Understanding was verbalized. Effective on 11/22/22 it is the responsibility of the direct care staff to remove any objects found blocking any doors/egress immediately or if unable to remove it is the direct care staff's responsibility to verbally report to the administrator immediately. The administrator will then assess and address appropriate removal of any object blocking/hindering egress. This inspection of the doors/egress is to be performed daily as cleaning of the porch areas are addressed.

Directed

- *On 11/22/22, the Direct Care Staff member removed the rock from the gate.*
- *On 11/22/22, the administrator inspected the area and removed any objects that can be used to block gates*
- *On 12/1/22, the administrator provided verbal education to all residents on the dangers of blocking exits, as well the requirement to report any hazards to a staff member immediately.*
- *Beginning 11/22/22, it is the responsibility of the direct care staff to immediately remove any objects found blocking any doors/egress or if unable to remove it is the direct care staff's responsibility to immediately verbally report the issue to the administrator.*
- *Beginning 1/3/23, the administrator will assess and address appropriate removal of any object blocking/hindering egresses. The administrator will complete daily inspections of the doors/egress to ensure the cleaning of the porch and gate areas.*

Directed Completion Date: *12/22/2022*

Implemented [redacted] - 01/25/2023)

132a - Monthly Fire Drill

8. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home did not conduct an unannounced fire drill in October 2022.

Plan of Correction ***Accept [redacted] - 12/27/2022)***

The last fire drill was on 9-25-22. The observed fire drill was scheduled for 10/18/22 and had to be rescheduled, due to the unavailability of the fire department representative, for the evening of 11/2/22. On the morning of 11/2/22 we had a case of Covid and were placed on lock down. It was the administrator's overlook to notify our licensing department that we were not able to complete the required fire drill and failure to have a drill in October due to having the observed drill scheduled for November 2. November's drill was completed 11/28/22. If in the future a fire drill is not able to be completed the Department of Human Services will be notified by the administrator. This

132a - Monthly Fire Drill (continued)

will come effective immediately (Dec 2022). The administrator will be responsible for monthly fire drills and documentation of such fire drills. They are documented in the fire drill file and was missed due to Covid and unable to be performed. Now that this occurred and the administrator is aware, the administrator will report if there are any circumstances preventing a monthly drill effective immediately to DHS. If there is a need to reschedule the administrator will still carry out a fire drill and document in existing folder.

Licensee's Proposed Overall Completion Date: *12/22/2022*

Implemented (01/08/2023)

141b1 - Annual Medical Evaluation

9. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Page 1 of Resident 1's medical evaluation dated /22 was not completed or present in the resident's record.

Plan of Correction ***Accept - 12/23/2022)***

The resident's annual medical evaluation was completed on /22. There were 2 page # 2 and the first page was not copied and placed in the chart. The correct page of the physical was added to the resident's record on 11/23/22 by administrator's designee (direct care staff member). In order to address the issues with documentation in the charts the administrator added a checklist on 12/1/22 to the resident's chart to help with organization and make sure all required components were in the chart. The resident's chart has all required components and both page 1 and page 2 of the resident's recent physical dated 4/19/22 is located in resident's chart. The administrator will review resident charts monthly and add a checklist to each resident's chart and begin to review monthly starting January 2023. The checklist will include, current physical DME and MA-51 (if applicable), contract, pre-admission screening, coversheet and contact information, current RASP, current dated picture, insurance card information, MAR, medication orders, updated POA and updated POLST (if applicable). It will be the responsibility of the administrator and/or designated direct care staff employee) to review resident records monthly and document such review on the checklist.

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

Implemented - 01/08/2023)

224a - Preadmission Screen Form

10. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 2's preadmission screening form, was not completed and therefore does not include a determination that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form *(continued)*

Plan of Correction ***Accept [redacted] - 12/23/2022)***

A pre-admission screening had been completed on [redacted]/22 by the administrator prior to resident's admission date of [redacted]22 and it had been determined that the home was able to meet the resident's needs. The pre-admission form was in a separate folder and had not been added to the resident's chart after admission. The administrator placed the preadmission form in the resident's chart on 11/23/22. The administrator will do initial chart check and review charts monthly to make sure all necessary paperwork/required documentation is located in resident's record. The administrator did a full review of the resident's record on 11/23/22. The initial finding of the preadmission screening form was corrected on 11/23/22. All resident charts will be reviewed beginning Jan 2023 using a checklist that was developed by the administrator on 11/30/22. This checklist will be added to all resident charts in January 2023 and all charts will be reviewed at this time and a check list that includes (DME, MA-51 within date requirements based on initial admission or yearly review, POA info, Preadmission screening, contract, insurance information, current resident picture, MAR and medication orders, cover sheet, POLST (if applicable) will be added to every chart in January when the initial review is completed. New resident's charts will be reviewed and the checklist completed by the administrator upon admission and then monthly thereafter. This will also assist identifying documentation, including but not limited to physicals and RASPs that need updated annually.

Licensee's Proposed Overall Completion Date: *01/07/2023*

Implemented [redacted] - 01/08/2023)