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

May 1, 2023

[redacted]
CHRIST THE KING MANOR INC
[redacted]

RE: CHRIST THE KING MANOR
1100 WEST LONG AVENUE
DUBOIS, PA, 15801
LICENSE/COC#: 44864

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/14/2023, 03/15/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CHRIST THE KING MANOR* **Licen e #**: *44864* **Licen e Expiration**: *06/20/2023*

Address: *1100 WEST LONG AVENUE, DUBOIS, PA 15801*

County: *CLEARFIELD* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *CHRIST THE KING MANOR INC*

Address [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *08/15/1996* **I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/15/2023*

Inspection Dates and Department Representative

03/14/2023 On Site [redacted]

03/15/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Alzheimer's Unit* **Capacity**: *20* **Residents Served**: *18*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *55*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *19* **Have Physical Disability**: *0*

Inspections / Reviews

03/14/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/06/2023*

04/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/25/2023*

Inspections / Reviews *(continued)*

04/14/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/14/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/20/2023*

05/01/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/14/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

The following residents had enabler bars attached to their beds that had the following measurements which were not securely covered, posing an entrapment hazard:
Resident #1, bed enabler opening measured 16 3/4 inches by 10 inches in room
Resident #2, bed enabler opening measured 19 inches by 13 1/2 inches in room
Resident #3, bed enabler opening measured 19 inches by 13 1/2 inches in room
Resident #4, bed enabler opening measured 19 inches by 13 1/2 inches in room
Resident #5, bed enabler opening measured 12 inches by 9 inches in room
Resident #6, bed enabler opening measured 19 inches by 13 1/2 inches in room

Plan of Correction ***Accept - 04/11/2023)***

On 3/16/2023, the Administrator took corrective action and placed a secured cover over the enabler bars in rooms . The residents and families will be provided written education regarding the safety with the use of an enabler, to include information on why a secured cover is important by 4/15/2023. All staff will be educated on the importance of enable safety, to include the importance of a secure cover, at our next all staff meeting on 4/20/2023. Beginning 4/1/2023, the Administrator, Resident Wellness Director, or Resident Care Coordinator will audit all enablers on a monthly basis to ensure that they are secured to the bed appropriately, clean, in good repair, free of hazards, and have an appropriate secured cover on them. We will keep these on file and review these quarterly at our Risk Management meeting and the next one is 4/26/2023.

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented 05/01/2023)

91 - Telephone Numbers

2. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers on or by the telephone in the smoking hut.

Plan of Correction ***Accept 04/11/2023)***

On 3/16/2023, the Director of Environmental Services took corrective action and placed emergency telephone numbers by the telephone in the smoke hut. Staff will be educated on the importance of having emergency telephone numbers by all outgoing phones at the all staff meeting on 4/20/2023. Beginning 4/1/2023, the Administrator, RWD, or RCC will be responsible to audit all phones that can make an outgoing call to ensure there are emergency phone numbers listed by them. Any phones that are able to make outgoing calls that are found to be without an emergency phone list will be required to be corrected immediately upon discovery and the Administrator, RWD, or RCC must have a second sign off that it was corrected.

91 - Telephone Numbers *(continued)*

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented [redacted] - 05/01/2023)

101j7 - Lighting/Operable Lamp

3. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #5 does not have access to a source of light that can be turned on/off at bedside. The resident's lamp is at the foot of the bed and cannot be reached at bedside.

Resident #7 does not have access to a source of light that can be turned on/off at bedside. The resident's lamp is at the foot of the bed and cannot be reached at bedside.

Plan of Correction ***Accept [redacted] 04/11/2023)***

On 3/15/2023, the Director of Environmental Services took corrective action and placed an operable lamp within reach of the head of the bed of Resident's #5 and #7, so that they can reach them to turn them on from the bedside. Staff will be educated at our next all staff meeting on 4/20/2023, the importance of having an operable lamp at the bedside of the residents bed, where they can reach it. Administrator will educate residents at resident council on May 2, 2023, about the importance of having an operable lamp at bedside that they can reach. Beginning 4/1/2023, the DES and/or Administrator will audit each resident's room to ensure that there is an operable lamp at bedside that the resident can reach. If there is not, it will be required to be corrected immediately and signed off by the opposite party to verity that it was corrected. These audits will be reviewed at our risk management meetings quarterly and the next one is to be on 4/26/2023.

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented [redacted] - 05/01/2023)

132c - Fire Drill Records

4. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the following drills conducted does not include that all residents evacuated during the fire drill:
On 9/7/23 at 4:30 p.m., 56 residents were present in the home; however, the fire log indicated only 37 residents were evacuated.
On 10/24/22 at 4:00 a.m., 53 residents were present in the home; however, the fire log indicated only 19 residents were evacuated.
On 11/22/23 at 1:45 p.m., 50 residents were present in the home; however, the fire log indicated only 35 residents

132c - Fire Drill Records (continued)

were evacuated.
On 12/17/22 at 10: p.m., 54 residents were present in the home; however, the fire log indicated only 18 residents were evacuated.
On 1/28/23 at 6:05 a.m., 53 residents were present in the home; however, the fire log indicated only 33 residents were evacuated.
On 2/23/23 at 12:00 p.m., 52 residents were present in the home; however, the fire log indicated only 19 residents were evacuated.

Plan of Correction ***Accept (04/11/2023)***

On 3/16/2023, the Administrator took corrective action and documented the next fire drill on the fire drill record, with all mandatory documentation and in correct location on the form. Previously, the census was written on the fire drill record, however, the number evacuated that was written down was only specific to the unit that the fire drill was conducted, either Alzheimer's unit or Personal care unit, though staff would headcount all residents during the fire drill. Beginning 3/16/2023, the Administrator will ensure that the fire drill log is filled out correctly and completely, ndicating the full census of residents evacuated, not just the number of residents specific to the unit the fire is ndicated on. The Administrator educated the DES on 3/15/2023, who also oversees the skilled division, what the Personal Care Home Regulations require for documentation regarding the fire drill log, as provided by the PA DHS website. DES will verify monthly, beginning 3/16/2023, that the Administrator is logging the fire drill information correctly as well and the total census is being recorded as evacuated, not only those on the unit the fire drill is performed.

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented (- 04/14/2023)

132g - Fire Drills Days/Times

5. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills with additional staff persons present. On 10/24/22, at 4:00 a.m., a fire drill was conducted with 7 staff members; however, only 4 staff members were scheduled as working that shift.

Plan of Correction ***Accept - 04/11/2023)***

On 3/16/2023, the DES took corrective action and performed a night shift fire drill at 4:00am, with 3 staff persons on shift, and they evacuated a total of 52 residents in 4m and 15s. The Administrator educated the DES on 3/15/2023, who also oversees the skilled division that is connected to the Personal Care division, that PA Personal Care Home Regulations only allow the PC division to utilize PC staff to evacuate during a fire drill and it is only the staff that is working during that specific shift, no additional staff is to be scheduled during these fire drills, and we do not choose our dates based on a low census. Beginning 3/16/2023, the DES will to perform the fire drills and the Administrator will verify and sign off that the fire drill log, verifying that all information is correct and that none of the above nformation looks to be true. If there is anything in question, the Administrator will discuss with DES immediately to ensure that the fire drills are being completed in compliance with this regulation. Education will be provided to all staff at the all staff meeting on 4/20/2023, regarding the importance of this regulation, in the event of a true emergency. We will review the monthly fire drills for compliance at our quarterly Risk Management meetings and the next one is 4/26/2023.

132g - Fire Drills Days/Times *(continued)*

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented [redacted] 04/14/2023)

233c Key Locking Devices

6. Requirements

2600.
233.c. If key locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism were conspicuously posted near the door to the Secure Dementia Care Unit (SDCU). However, the manner in which it was posted did not clearly indicate the sequential order the numbers needed entered in the keypad preventing immediate egress from the SDCU for visitors.

Plan of Correction ***Accept [redacted] 04/11/2023)***

On 3/15/2023, the Resident Wellness Director, took corrective action and created a new posting to display the code of which is needed to exit the Secured Dementia Unit. The staff will be educated at the all staff meeting on 4/20/2023 of the importance of these postings, how, and why they have to be posted the way that they do per the regulations. Beginning 4/1/2023 the RWD will be responsible to create a new monthly posting to start on the 1st of each month to conspicuously display the code to exit the Secured Dementia Unit. The Administrator will be responsible to review and approve the posting prior to display on the 1st of each month beginning 4/1/2023.

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented [redacted] 05/01/2023)