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

July 5, 2023

[redacted]
I SAW THE LIGHT LLC
[redacted]

RE: SOUTH FORK WELCOME HOME
316 MAIN STREET
SOUTH FORK, PA, 15956
LICENSE/COC#: 33771

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *SOUTH FORK WELCOME HOME* **Licen e #**: *33771* **Licen e Expiration**: *10/04/2023*

Address: *316 MAIN STREET, SOUTH FORK, PA 15956*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *I SAW THE LIGHT LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *12/27/1994* **I ued By**: *D L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

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

Inspection Dates and Department Representative

03/15/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* **Residents Served**: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older**: *14*

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

03/15/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/03/2023*

04/12/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/03/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/17/2023*

Inspections / Reviews *(continued)*

05/24/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/12/2023*

07/05/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/03/2023*

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

51 - Criminal Background Check

1. 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

Staff Person A, who was hired on [redacted]/2022, did not have a criminal background check completed.

Plan of Correction ***Directed ([redacted] - 05/11/2023)***

This regulation is extremely important to ensure that people who have committed crimes that are not compatible with working with our residents are not employed by our facility. Staff person A did have the initial criminal background check prior to beginning [redacted] employment that was submitted by [redacted], but that check came back with a control number and the final report was not printed. A secondary background check was completed by [redacted] on 4/1/2023, and staff has no criminal record.

Directed - 5/11/23
- The Administrator will develop a new hire checklist by 6/9/23, to include criminal background checks, to ensure they are completed timely.
- The Administrator will complete an audit of all employee files to ensure criminal background checks are in place by 6/9/23.

Directed Completion Date: *06/09/2023*

Implemented ([redacted] - 07/05/2023)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On 3/15/23 at approximately 3:25 pm, a stack of approximately 3-inch high, red plastic cups were observed on top of the medication cart. These cups had taped-on labels with the residents' first names. Residents' first names were written on the inside top rim in permanent marker. The inside of the cups had dark dusty stains and a powdery residue. Staff Person B stated that the pills were popped from the blister packs into these cups Staff Person B confirmed that the cups were reused. Once used, these medication cups are re-stacked and used for the next medication pass, which leads to cross contamination and unsanitary conditions.

Plan of Correction ***Directed ([redacted] - 05/12/2023)***

This regulation is important to ensure that medications are being passed appropriatley and that all are cleaned after each use to ensure cross cantamination does not occur. We have since disposed of all cups with names and employees are now required to use a new cup each medication pass.[redacted] threw all cups out and a training was completed with all staff on not using the cups more than one time uness they have been properly washed.

85a - Sanitary Conditions (continued)

Additionally, the cups are never permitted to have an individuals name attached to them. Staff training was completed on 4/5/2023. There has also been a weekly tool that has been implemented that wil allow medication checks and cart audits to be completed weekly. This audit will be completed every friday.

Directed -
- Starting 6/1/23, the Administrator or designated staff will begin daily checks of the medication cart to ensure medication cups are not reused. Starting 7/1/23, the Administrator or designated staff will complete weekly checks to ensure medication cups are not being reused.

Directed Completion Date: *07/31/2023*

Implemented ([redacted] - 07/05/2023)

85d - Trash Receptacles

3. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 3/15/23 at approximately 10:17 am, the trash can in the kitchen was 3/4 full of trash and uncovered. Upon reentering the kitchen at approximately 2:30pm, the trash remained uncovered.

On 3/15/23 at approximately 9:40 am, the trash can in the shared bathroom at the front entrance was observed with trash in the can and the trash can was not covered.

Repeat Violation - 4/5/2022

Plan of Correction ***Directed ([redacted] - 05/12/2023)***

The identified trash receptacles were covered by the administrator on 3/31/2023. New cans were ordered and one was placed in the small bathroom and the kitchen trash was removed entirely as there is not space for a trash can with a lid to fit in the designated area. Staff were trained on the importance of each trash can having an atttached id and it will be documented during daily checks/cleanings in our daily log that all trash have lids. The manager Joni Susko will do daily checks monday- friday beginning 4/5/2023, and discuss any need with the administrator.

Directed -
- Starting 6/1/23, the Administrator or designated staff will complete a daily walk through of the home to ensure all trash cans are covered for one month. Starting 7/1/23, the Administrator or designated staff will do a weekly audit to ensure all trash cans are covered and have lids in place.

Directed Completion Date: *07/31/2023*

Implemented ([redacted] - 07/05/2023)

89b - Hot Water Temperature

4. Requirements

89b - Hot Water Temperature *(continued)*

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 3/15/23 at approximately 2:45 pm, the hot water temperature in the bathroom across from Resident #2's room on the first floor was 122.3 degrees Fahrenheit and at approximately 4:20 pm the hot water was 123.2 degrees Fahrenheit.

On 3/15/23 at approximately 2:40 pm, the hot water temperature in the bathroom across from the down stairs was 122.7 degrees Fahrenheit and at approximately 4:25 pm the hot water was 123.2 degrees Fahrenheit.

Repeat Violation - 4/5/22

Plan of Correction ***Accept (- 05/11/2023)***

This regulation important to ensure that residents do not get burned on water temperatures that are too high. I do not believe the calibration is correct on the thermometer that was being used as all of our temeratures before and since are reading at accurate levels between 115-119. Additionally our plumber checked the tank and it is set for 115 on 3/21/2023 by Hinkle Plumbing and Heating. All readings in all bathrooms have read at 115 or below weekly since this was done. All staff are to monitor the numbers daily in the log book. Training was completed to ensure that this is being done on 4/5/2023 and future log books will have an area for this information to be input.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented (- 07/05/2023)

100b - Removal Snow/Obstructions

6. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 3/15/23 at approximately 9:10 am, there was approximately a 2-3 inch accumulation of snow outside of the emergency exit in the dining room. This snow was on a deck as well as on the stairs leaving the deck. At approximately 5:00 pm, the snow was still on the deck and the stairs not treated.

Plan of Correction ***Directed (- 05/11/2023)***

This regulation is important to ensure that residents are able to safely evacuate the facility. The day in question, it had just snowed that nightand snow had lightly accumulated on the back deck. It has since been taken care of and the staff have been maintaining it along with the other areas of the facility. A pathway was cleared by Joni while the nvestigator was there and the remaining snow which wa only a light dusting had melted by the time the nvestigator had left the facility. Staff have been advised that snow on the deck also needs frmoved when all other areas are being done. This was discussed at the staff meeting/ training on 4/5/2023.

100b - Removal Snow/Obstructions (continued)

Directed - 5/11/23
- , Beginning 4/5/23 and continuing daily when it snows, the Administrator or designated staff will check the deck daily to ensure snow does not need to be removed from the deck.

Directed Completion Date: *06/01/2023*

Implemented (- 07/05/2023)

101j1 Mattress Fire Retardant

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 3/15/23 at approximately 4:30 pm, the top of the mattress on Resident #7's bed was shredded and holes exposed the inside of the mattress..

Plan of Correction ***Accept (05/11/2023)***

This reguation is important to ensure that all residents are able to sleep in a safe and comfortable environment. The bed was the residents personal bed, not the facility's. The resident in question was puncturing the bed/floors/ walls/ceiling and window seals with various different objects. Additionally, was caught smoking in room and was given a 30-day notice. During that time period after the notice was caught smoking several more times and when told that could not do that told the staff to "F-off. His last day at out facility was 2023. A new bed has been put in place for a new resident to move in. Staff will check and monitor all beds during weekly sheet changes and notify immediately of any concerns such as hazards.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented (- 07/05/2023)

101j3 - Bed/Linens/Pillows/Blankets

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 3/15/23 at approximately 10:15 am, there were no linens observed on the beds of Residents #5 and #7. Upon return to the room at approximately 4:15 pm, there were still no linens on either of the beds.

Plan of Correction ***Accept (- 05/11/2023)***

This regulation is important to ensure the resident is comfortable and safe in their environment. The residents in question both have support plans due to them taking their linens off of their beds and throwing them on the floor because they "do not want them" They are placed back on the beds during 7am checks and the residents take them off again. A support plan was put in place for resident #7 on /2019. The support plan for resident #5 was put

101j3 - Bed/Linens/Pillows/Blankets (continued)

n on [redacted]/2020. I have attached the support plans for each resident [redacted]. One resident was given a 30-day notice and has vacated the facility, the other resident is still having the same issues and their support plan is also in place. Both residents spend a lot of time in thier beds and it is nearly impossible to ensure their bedding is on at all times which is why they have support plans. Staff will do dailt bed checks at 7am and 7pm and place the bedding back on their beds at that time beginning 4/14/2023.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented ([redacted] - 07/05/2023)

101j7 - Lighting/Operable Lamp

9. 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

Residents #4, #5 and #6 do not have access to a source of light that can be turned on/off at bedside.

Repeat Violation - 4/5/22

Plan of Correction ***Directed ([redacted] - 05/11/2023)***

This regulation is important to ensure that residents are safe at all times including in the event that they wake up at night and need a light to see. Due to constant breaking and or moving of the light fixtures that we place by the residents beds, we are meeting with the electrician on 3/31/2023 to see how/if permanent fixtures can be added to each area above the beds. If not, we will look at other solutions that are not able to be moved by the resident. Currently all residents have a flashlight by their beds. We are hoping to have the more permanate solution installed by May 20, 2023.

Directed - 5/11/23
- Starting 6/1/23, the Administrator or designated staff will complete audits of all occupied resident rooms daily to ensure each resident has a light source at bedside.

Directed Completion Date: *06/30/2023*

Implemented ([redacted] - 07/05/2023)

101o - Walls, Floors, Ceilings

10. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The ceiling above the bed of Resident #5 in the [redacted] bedroom of Residents #5 and #7 has water damage stains on the ceiling tile and another ceiling tile is missing.

Plan of Correction ***Accept ([redacted] - 05/11/2023)***

There was a roof leak on 3/4/2023, the roofer was contacted, he came in to look at it on 3/8/2023 and patched the area. The work is scheduled to be fully completed 4/17/2023 weather permitting as the area that needs to be repaired is extremely high and steep. A weekly monitoring tool has been implemented and will be completed on

101o - Walls, Floors, Ceilings (continued)

fridays by staff member [redacted]

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented ([redacted] - 07/05/2023)

103f - Refrigerator/Freezer Temps

11. 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 3/15/23 at approximately 10:25 am, there was no thermometer in the Crosley Shelvador white freezer in the pantry in the basement.

On 3/15/23 at approximately 10:30 am, the temperature in the black Frigidaire freezer portion of the refrigerator/freezer was 18 degrees Fahrenheit. At approximately 3:00 pm, the temperature in the freezer was rechecked and it was 17 degrees Fahrenheit. This freezer contained 2 pork roasts and beef soup bones.

Plan of Correction ***Accept ([redacted] - 05/11/2023)***

This reguation is extremely important to ensure that residents food is stored in the proper temperature so that bacteria does not grow and make residents and/or staff ill. After checking the freezer it has been determined that the temerature gage that was being used was broken. Since placing a new one in the freezer, it is reading at below zero degrees. Staff have been spoken to in regards to ensuring that all fridges and freezers are checked each shift and if there is a discrepancy between numbers, the temperature gage needs to be checked to ensure its working properly and if that is not the problem, all food should be removed from that area and stored in another place until the issue s resolved. New thermometers were added 4/5/2023, by T. Ibrahim. Training was provided on 4/5/2023, and all refrigirators/ freezers will be monitored daily and T.Ibrahim will be notified of any temeratures that are too high or if a thermometer is broken/ missing. A space is provoded in the log book for each shift to write in. This is to begin on 4/5/2023.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented ([redacted] - 07/05/2023)

104b - Dishes/Glassware/Utensils

12. Requirements

2600.
104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

On 3/15/23 at approximately 10:15 am, multiple plates and bowls, which the residents use regularly, were observed with chips on the sides of the plates and bowls.

104b - Dishes/Glassware/Utensils *(continued)*

Plan of Correction ***Directed (MD 05/12/2023)***

This regulation is important because we want to ensure that residents do not get cut or accidently ingest a piece of ceramic do to a chip. Upon further inspection there were two plates and 1 bowl that were chipped in the cupboards that could have been used by a resident. In an abundance of caution and to avoid an issue like this in the future, all items were taken out and replaced with a durable plastic material that is both dishwasher and microwave safe eliminating the threat of a safety concern. Staff will monitor plates and bowls daily as they are using them. Any that are chipped or in disrepair should be thrown out immediately. The bowls and dishes were replaced 3/20/2023 by [redacted]

Directed -
- By 6/9/23, all staff will be educated on the inability to use chipped dishes and glasses.
- The Administrator will complete an audit of the dishes monthly to ensure all dishes are safe to use, starting 6/1/23.

Directed Completion Date: *06/30/2023*

Implemented ([redacted] - 07/05/2023)

185a - Implement Storage Procedures

16. 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

On 3/15/23, Resident #3's [redacted], [redacted], and [redacted] are ordered pro re nata (PRN) as observed on the Medication Administration Record (MAR), however these medications were not available in the home.

On 3/15/23 at approximately 4:30 pm, a pink, oblong pill was observed unlocked, unattended, and accessible in a hole in middle of the mattress in Resident #7's room.

During a review of Resident #1's [redacted] glucometer and the MAR, the following was observed:

- *The 3/3/23 8:00 am blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/3 at 5:43 am shows [redacted].*
- *The 3/1/23 8:00 am blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/1 at 5:55 am shows [redacted]*

During a review of Resident #2's [redacted] glucometer and the MAR, the following was observed:

- *The 3/10/23 5:00 pm blood sugar reading in the MAR is documented as [redacted] however the glucometer reading for 3/10 at 4:31 pm shows [redacted]*
- *The 3/6/23 5:00 pm blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/6 at 4:4 5pm shows [redacted].*
- *The 3/5/23 8:00 am blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/5 at 6:12 am shows [redacted].*
- *The 3/3/23 5:00 pm blood sugar reading in the MAR is documented as [redacted] however the glucometer reading for 3/3 at 4:45 pm shows [redacted]*

During a review of Resident #3's [redacted] glucometer and the MAR, the following was observed:

185a - Implement Storage Procedures (continued)

- The 3/9/23 6:00 am blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/9 at 7:11 am shows [redacted]
- The 3/4/23 6:00 am blood sugar reading in the MAR is documented as [redacted] however the glucometer reading for 3/4 at 6:40 am shows [redacted]

Plan of Correction ***Accept ([redacted] - 04/12/2023)***

Medication administration is an extremely important part of our facility and ensuring that residents receive the 5 rights is a must.
On 3/15/23, Resident #3's [redacted], [redacted], and [redacted] are ordered pro re nata (PRN) as observed on the Medication Administration Record (MAR), however these medications were not available in the home. - [redacted] for this resident was not reordered as the physician has refused to order this medication and that physician has also not sent a [redacted] order to the pharmacy dispite multiple requests to do so. The other two medication have also been requested for [redacted] orders by the physician and pharmacy has not recieved those either.

On 3/15/23 at approximately 4:30 pm, a pink, oblong pill was observed unlocked, unattended, and accessible in a hole in middle of the mattress in Resident #7's room.
It appears that this resident was "pocketing" pills in [redacted] mouth that [redacted] did not want to ingest and hiding them in different areas. This resident was causing several issues throghout the facility and was given a 30 day notice.

During a review of Resident #1's [redacted] glucometer and the MAR, the following was observed:

The 3/3/23 8:00 am blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/3 at 5:43 am shows [redacted].
The 3/1/23 8:00 am blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/1 at 5:55 am shows [redacted]
During a review of Resident #2's [redacted] glucometer and the MAR, the following was observed:

The 3/10/23 5:00 pm blood sugar reading in the MAR is documented as [redacted] however the glucometer reading for 3/10 at 4:31 pm shows [redacted]
The 3/6/23 5:00 pm blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for 3/6 at 4:4 5pm shows [redacted]
The 3/5/23 8:00 am blood sugar reading in the MAR is documented as [redacted] however the glucometer reading for 3/5 at 6:12 am shows [redacted]
The 3/3/23 5:00 pm blood sugar reading in the MAR is documented as [redacted] however the glucometer reading for 3/3 at 4:45 pm shows [redacted].
During a review of Resident #3's [redacted] glucometer and the MAR, the following was observed:

The 3/9/23 6:00 am blood sugar reading in the MAR is documented as [redacted], however the glucometer reading for

185a - Implement Storage Procedures (continued)

3/9 at 7:11 am shows [redacted]
The 3/4/23 6:00 am blood sugar reading in the MAR is documented as [redacted] *however the glucometer reading for 3/4 at 6:40 am shows* [redacted].

All staff attended diabetic training on march 16, 2023. Additionally, staff were retrained by myself on the importance of writing the number as soon as you take it instead of trying to remember them which is what was happening. I will be completing bi-weekly checks on all glucose readings with a special area to document any findings. All staff will have a secondary more in depth training at the next staff meeting which is scheduled for April 11, 2023. This meeting will go over medication administration and we will go over a new policy and procedure that will be put in place t ensure errors like above are not occuring in the future. The new policy will include medication training and loss of med tech privilages if 3 or more mistakes are made within a 3 month period by any staff.

Licensee's Proposed Overall Completion Date: *03/30/2023*

Implemented ([redacted] - 07/05/2023)