Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

June 1, 2023

MORNING GLORY SENIOR LIVING INC
419 N. QUEEN STREET
LITTLESTOWN, PA, 17340

RE: MORNING GLORY SENIOR LIVING
419 N. QUEEN STREET
LITTLESTOWN, PA, 17340
LICENSE/COC#: 31280

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/12/2023 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MORNING GLORY SENIOR LIVING* **Licen e #**: *31280* **Licen e Expiration**: *03/21/2024*

Address: *419 N. QUEEN STREET, LITTLESTOWN, PA 17340*

County: *ADAMS* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MORNING GLORY SENIOR LIVING INC*

Address: *419 N. QUEEN STREET, LITTLESTOWN, PA, 17340*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *12/31/2001* **I ued By**: *Labor and Industry*

Type: *C 2 LP* **Date**: *12/28/2001* **I ued By**: *Borough of Littlestown*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *10* **Waking Staff**: *8*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/12/2023*

Inspection Dates and Department Representative

04/12/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *12* **Residents Served**: *10*

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**: *10*

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

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

Inspections / Reviews

04/12/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/30/2023*

Inspections / Reviews *(continued)*

04/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/31/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/04/2023*

05/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/31/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/31/2023*

06/01/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/31/2023*

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 has a gas furnace in the basement. According to the Care Facility Carbon Monoxide Alarm Standards Act, a carbon monoxide detector is required within 15 feet of a fossil fuel burning device. There is no Carbon Monoxide detector within 15 feet of the natural gas furnace.

Plan of Correction ***Accept (- 05/02/2023)***

On April 12, 2023 Administrator purchased a carbon monoxide detector and installed it on that day. The weekly checks were started on April 16th We do our annual battery replacement on January 5th beginning in 2024. , Administrator and Administrator take care of this.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 06/01/2023)

65b - Rights/Abuse 40 Hours

2. 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:

1. Resident rights.
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Member B's 1st day/ 1st 40 hours training does not include training in the topics of Resident rights or Reporting of reportable incidents and conditions.

Repeated Violation - 4/20/22

Plan of Correction ***Accept (- 05/02/2023)***

Staff member B's 1st day/ 1st 40 hours training did not include training in the topics of resident rights and reportable incidents. On April 13, 2023 Administrator along with Staff B reviewed Residents Rights and Reporting reportable Inncidents. administrator and staff B signed and dated that form and it was put in staff B employee folder. administrator made copies of the corrected resident rights and the reportable incidents form and put them in the staff training folder, this was done on 4/13/2023, we have folders for each new employee. In the future both Administrator and Administrator will check to see if the forms are initialed and dated. This will be reviewed on Dec, 6 ,2023 during our annual quality manegment review meeting.

Licensee's Proposed Overall Completion Date: *04/28/2023*

65b - Rights/Abuse 40 Hours *(continued)*

Implemented (- 06/01/2023)

65g - Annual Training Content

3. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

The home could not produce the annual training records for Staff Members A or B for the following topics:

- *Fire safety*
- *Emergency preparedness procedures*
- *Resident rights*
- *Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)*
- *Falls and accident prevention*
- *New population groups that are being served at the home*

Plan of Correction ***Accept (- 05/02/2023)***

Staff members A or B were not trained for fire safety, emergency preparedness procedures, resident rights, Older Adult Protective Services act, falls and accident prevention, New population groups being served. Administrator has added these topics to the staff members folders and they are going over them now and when completed they will sign and initial. We are going to develop a new notebook to keep this training in for direct care staff, ancillary and volunteers. The training on these topics was studied and reviewed by Staff member A and Staff Member B on 04/13/2023 Administrator Initiated and Completed the trainings with the staff member A and Staff member B. Administrator updated the staff training folders on 04/13/2023. This will be reviewed and discussed on our next Quality management review on 12/06/2023

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 06/01/2023)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Located in the kitchen, under the kitchen sink, were the following products :

82c - Locking Poisonous Materials (continued)

1.5-pint bottle of [redacted] Bleach
32oz spray bottle of [redacted] all-purpose cleaner
13oz can of [redacted] oven cleaner

The following was found inside the first-floor bathroom, under the sink:
32oz bottle of [redacted] mold and mildew remover

All chemicals included warning labels of being harmful if swallowed as well as to contact poison control if ingested. All chemicals were unlocked and accessible to the residents, including Resident 2 whom has been assessed as not being able to safely avoid poisons.

Plan of Correction ***Accept (05/02/2023)***

There were poisonous materials unlocked in the home. We will put up a sign to remind the staff to lock all of the poisonous materials after each use. When each new shift comes in to work they are also to check and make sure that they are all locked up..We will also discuss this at our next staff meeting in May.The poisonous materials were ocked up By [redacted] administrator on April 12, 2023. [redacted] administrator also put up the reminder sign on April 12, 2023. We have a daily checklist for each employee to date and initial at the end of every shift change. This is on front of the storage cabinets. Our staff meeting is scheduled for May 17, 2023

Licensee's Proposed Overall Completion Date: *05/04/2023*

Implemented (- 06/01/2023)

132c - Fire Drill Records

6. 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 drill conducted on 11/16/2022 does not include a specific time when the fire drill took place; it only indicates that it was during the "3-11" shift.

Plan of Correction ***Accept (- 05/02/2023)***

The fire drill that was conducted on 11/16/2022 during the 3-11 shift did not have the time recorded. I have written n a red sharpie to remember to put the time that the fire drill was conducted. This will be checked by me, [redacted] ,administrator to be sure that it has been filled out completely, beginnning 5/01/23. The fire drill reviews will be discussed at the quality management meeting scheduled for December 6, 2023. Administrators [redacted] and [redacted] are the attendees.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 06/01/2023)

141a Medical Evaluation

7. Requirements

141a - Medical Evaluation *(continued)*

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.

Description of Violation

The Documentation of Medical Evaluations (DMEs) for Resident 1, dated /2022, and Resident 2, dated /2022, do not include each residents' height listed on the forms.

Repeated Violation - 4/20/22

Plan of Correction ***Accept (- 05/02/2023)***

The medical evaluation for resident 1 dated /2022 and the one for resident 2 dated / /2022 did not have their height on them. We have measured them and put their height on their medical evaluations. , direct care staff takes care of faxing and receiving the medical evaluations. When they come back checks and makes sure that they are completed .After this administrator or Administrator will check them over to be sure they are completed before filing them away. Administrator, will go through all of the current medical evaluations and audit them to make sure they are completely filled in as required. This will be done by May 30, 2023

Licensee's Proposed Overall Completion Date: *05/30/2023*

Implemented (- 06/01/2023)

191 - Resident Right to Refuse

8. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

The resident records for Resident 1 and 2 do not include documentation that the home has educated the residents on their right to question or refuse a medication if the residents believe there may be a medication error.

Plan of Correction ***Accept (- 05/02/2023)***

The resident records for resident 1 and 2 do not have documentation that a resident has the right to question or refuse a medication if they believe there is an error. We are adding this resident right to the resident rights poster that we received from the state. This will be on a separate sheet of paper and will state that they do have the right to question or refuse a medication if they believe there was an error.. We will add this to all residents folders and have them sign and date them.This was done today, 4/28/23 by Adminiistrator and all of them are in their folders.

New residents that move in beginning May 1, 2023 will initial the sheets with the right to question or refuse their medication if the believe there is an error.

Licensee's Proposed Overall Completion Date: *04/28/2023*

191 - Resident Right to Refuse *(continued)*

Implemented (- 06/01/2023)

252 - Record Content

9. 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

The photo for Resident 1 was a copy of the resident's Driver's License that was issued in

Repeated Violation - 4/20/22

Plan of Correction ***Accept (- 05/02/2023)***

The photo for resident 1 was not a current photo. administrator took a current photo and it is now in resident 1's folder. Instead of using a photo that a resident has whether it be a drivers license or a state id photo we will take a photo on Cathy Franek Administrator phone and have it developed at Walmart. Beginning 5/01/2023.We will take all future move-ins on the day of their arrival and will take their future picture yearly on the date of their annual medical evaluation.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 06/01/2023)