

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

August 28, 2023

[REDACTED], ADMINISTRATOR  
PRESBYTERIAN HOMES INC  
[REDACTED]

RE: PRESBYTERIAN HOME AT  
WILLIAMSPORT  
810 LOUISA STREET  
WILLIAMSPORT, PA, 17701  
LICENSE/COC#: 20054

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/11/2023 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.

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: PRESBYTERIAN HOME AT WILLIAMSPORT License #: 20054 License Expiration: 06/22/2023  
 Address: 810 LOUISA STREET, WILLIAMSPORT, PA 17701  
 County: LYCOMING Region: NORTHEAST

**Administrator**

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

**Legal Entity**

Name: PRESBYTERIAN HOMES INC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: Other Date: 08/19/1981 Issued By: PALI

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 26 Waking Staff: 20

**Inspection Information**

Type: Full Notice: Unannounced BHA Docket #:  
 Reason: Renewal Exit Conference Date: 07/11/2023

**Inspection Dates and Department Representative**

07/11/2023 - On-Site [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 27 Residents Served: 26  
 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: 26  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 0 Have Physical Disability: 0

**Inspections / Reviews**

07/11/2023 Full  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/09/2023

08/04/2023 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 08/22/2023  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/09/2023

Inspections / Reviews *(continued)*

08/18/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/22/2023

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 08/22/2023

08/22/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/22/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/22/2023

08/28/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/22/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

## 3c - Post Current License

## 1. Requirements

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

## Description of Violation

*This Licensing Inspection Summary (LIS) dated 5/6/2023 was not posted in a conspicuous public place in the home.*

## Plan of Correction

Accept (████) - 08/18/2023)

1. Staff Member A immediately printed out the License Summary for survey on 5/6/2023 from Sanswrite and posted on 7/11/2023.
2. Administrator reviewed DHS regulatory book posted for public and noted current Summaries are posted.
3. Administrator reviewed regulations and educated by the extender care manager on importance of summaries from previous year to renewal should be posted immediately once received.
4. Administrator will audit the Regulation for public notebook every 3 months to assure it stays up to date with summaries of most recent plan of correction.

Licensee's Proposed Overall Completion Date: 08/07/2023

Implemented (████) - 08/28/2023)

## 17 - Record Confidentiality

## 2. 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

*The Licensing Inspection Summary (LIS) dated 5/22/2022 located near the entrance of the home contained the resident privacy coding document. The resident privacy coding document exposes confidential information of the residents. The binder which contained the LIS also contained doctor's orders which contained confidential information of the residents.*

## Plan of Correction

Accept (████) - 08/18/2023)

1. Administrator immediately on 7/11/23 removed the License Summary that had resident information posted on.
2. Administrator reviewed DHS regulatory book posted for public and noted current Summaries are posted do not have resident information included.
3. Administrator reviewed regulations and educated by the extended care service manager on importance of summaries making sure to print the public labeled one to assure no information of HIPPA compliance should be in there.
4. Administrator will audit the Regulation for public notebook every 3 months to assure it stays up to date with summaries and not include resident information (public).

Licensee's Proposed Overall Completion Date: 08/07/2023

17 - Record Confidentiality (continued)

Implemented (████) - 08/28/2023)

18 - Compliance With Laws

3. 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 carbon monoxide detector in the basement contained undated batteries. The carbon monoxide detector on the 1st floor, outside the salon, contained batteries dated 8/2/2021. As per The Care Facility Carbon Monoxide Alarm Standards Act, the batteries must be dated and replaced annually at a minimum.

Plan of Correction

Accept (████) - 08/04/2023)

- 1. Carbon Monoxide alarms identified were changed and dated.
- 2. All Carbon Monoxide alarms were reviewed for battery dating & changed/dated if necessary
- 3. Administrator/ Maintenance will be educated to place battery checks on a preventative maintenance schedule for changing/dating timely.
- 4. Administrator will audit carbon monoxide alarms monthly for 3 months to be sure batteries have been dated/changed timely.

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented (████) - 08/28/2023)

64c - Annual Training

4. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff member A was only able to verify 9 training hours for 2022.

Plan of Correction

Accept (████) - 08/22/2023)

- 1. Administrator will be completing 33 hours of training by 12/03/2023 and that you have completed 25 # of hours so far through PSL Relias, PALA in Spring Conference, an online class of Staff Crisis, Straight Talk sessions, also attended Leading Age in May, Administrator has scheduled to complete the additional hours by registering for Temple Classes in October, two of them both equaling 6 hours, PALA conference in the fall Sept 26-28th to gain 14.5 credits and further completion of Relias classes through PSL. This total will equal 51.5 for all of 2023.
- 2. The Administrator Reviewed DHS regulations for the training requirements for the administrator on an annual basis.
- 3. The Administrator will file education a 1 year time frame for easy access and review.
- 4. Administrator will assure that training is complete on an annual basis and assure that kept for annual survey in binder to be easily accessible for surveyors to access. Administrator will review monthly to ensure that training is being completed to ensure that hours meet the regulatory requirement.

## 64c - Annual Training (continued)

Licensee's Proposed Overall Completion Date: 08/21/2023

Implemented ( ) - 08/28/2023

## 65a - FS Orientation 1st Day

## 5. 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 Member B hired ( ) did not have documentation that the first day fire safety orientation was completed on or before the first day worked.

## Plan of Correction

Accept ( ) - 08/04/2023

1. Staff person B completed training for Emergency medical plan on first day to the floor. Training was completed on first day of hire but not dated. Repeat training completed 7/12/23 and signed.
2. All recent hire charts were audited completed by the Administrator within 2 days of the survey to ensure required training was completed and dated correctly.
3. The New Employee Orientation Binder has been updated including a training topics sheet that includes Emergency Medical Plan. Personal Care Home Administrator reviewed policy and procedures to assure correct completion of appropriate paperwork according to DHS regulations for new employee orientation.
4. PCHA will use training topic form with each New Employee Orientation (NEO) including ancillary staff. After each NEO administrator will audit new employee charts to assure appropriate paperwork is completed, signed and dated appropriately.

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented ( ) - 08/28/2023

## 81b - Resident Personal Equipment

## 6. 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 enabler bar attached to the bed in room 110 has an approximate 12-inch opening which is not covered and could pose a risk of entrapment or injury.

## Plan of Correction

Accept ( ) - 08/04/2023

1. Bed Enabler was removed immediately from resident 110 bed.
2. Audit was performed in Matrix Care to assure no other residents had enablers ordered and or on the bed.
3. Bed Rail Policy was reviewed with staff. Education was provided to nursing staff related to the importance of Bed enabler's verses bed rails related to hazards that could have happened to resident.
4. Administrator will do an audit monthly x 3 months to ensure that any bed rail used meets the appropriate entrapment requirements and standards per policy.

81b - Resident Personal Equipment (*continued*)

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented (█) - 08/28/2023

## 82a - Poisonous Materials

## 7. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

## Description of Violation

Clear spray bottle labeled with black marker: "█" was found in the basement storage area. It did not have a manufacturer's label and was not in the original container.

## Plan of Correction

Accept (█) - 08/04/2023

1. Chemical bottle labeled coil cleaner was discarded immediately.
2. Through inventory taken of all chemicals, assured in properly labeled containers. Also in the locked chemical closet where they shall be stored as well.
3. Education provided for staff, housekeeping and nursing to assure if they accept chemicals they are placed in chemical closet not set in hallway. Also when chemicals are in closet or other areas they need to stay in the labeled container and door is to be locked and closed.
4. Administrator will perform audit in chemical room and housekeeping floors once weekly x 1 month once monthly x 3 months and once every 3 months x 6 months to assure compliance.

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented (█) - 08/28/2023

## 101j7 - Lighting/Operable Lamp

## 8. 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

Room 204 did not have an accessible light source at the bedside that could be turned on/off at the bedside.

## Plan of Correction

Accept (█) - 08/04/2023

1. Administrator went to room 204, placed lamp back on bedside stand.
2. Community wide audit was performed 7/13/2023 to assure all lamps were on bedside stands and functioning with a light bulb.
3. Resident was educated on the importance of a lamp being on bed side and that it was a regulation. Staff education was provided on 7/12/23 at monthly staff meeting the importance and reminders to be looking when in room providing care to ensure there is a functional lamp on the bedside stand.
4. Administrator and skilled maintenance will perform audits weekly x one month; monthly x three months and every 3 months x 6 months to ensure there is a functional lamp on the bedside stand.

Licensee's Proposed Overall Completion Date: 08/03/2023

101j7 - Lighting/Operable Lamp (continued)

Implemented ( ) - 08/28/2023

107a - Emergency Preparedness

9. Requirements

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

An interview with the homes Administrator indicated that the home does not have a copy of the local emergency management agency's emergency preparedness plan and is not familiar with the plan.

Plan of Correction

Accept ( ) - 08/18/2023

1. Administrator looked up on Lycoming County Website the municipality plan immediately after DHS left building on 7/11/23.
2. The Administrator called Williamsport Fire Department on 7/16/2023 related to having a municipality emergency plan verses PHW emergency preparedness
3. Education to Administrator was provided by the surveyor related to municipality verses PHW home emergency preparedness.
4. Administrator will assure that municipality plan is up to date and monitored on a quarterly basis monitoring for updates or changes.

Licensee's Proposed Overall Completion Date: 08/07/2023

Implemented ( ) - 08/28/2023

132a - Monthly Fire Drill

10. Requirements

2600.

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

Description of Violation

The home did not complete a fire drill in 2/2023 or 6/2023.

Plan of Correction

Accept ( ) - 08/04/2023

1. Completed June 28th fire drill documentation immediately.
2. Audit was performed to show the frequency of Fire Drills. Regulations were reviewed to assure compliance going forward.
3. Surveyor and Administrator discussed the importance of assure time of month changes every month. The time of day has to change every month. The surveyor also discussed the importance of clearing the COVID restriction time by the DHS office. Administrator and Maintenance will plan and schedule fire drills to capture a different time of day each month.
4. Administrator will audit fire drill log monthly to ensure that fire drill times vary each month.

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented ( ) - 08/28/2023

## 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 most recent fire safety inspection by a fire safety expert was completed 3/21/2023. The previous inspection by a fire safety expert was completed more than 1 year prior on 2/22/2022.*

## Plan of Correction

Accept (████) - 08/04/2023)

1. Fire Inspection was scheduled and completed on March 21st, 2023.
2. Administrator was educated regarding the regulation for annual fire inspection and need to schedule accordingly.
3. Audit will be conducted annually to be sure fire inspections are completed per the regulations.
4. Administrator will audit fire inspection letter annually to ensure that fire inspection is completed timely.

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented (████) - 08/28/2023)

## 132e - Fire Drill Sleeping Hours

## 12. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

## Description of Violation

*There was no fire drill completed during nighttime hours beginning 12/2022 through 6/2023.*

## Plan of Correction

Accept (████) - 08/04/2023)

1. Completed Night time Fire Drill on 7/13/2023 @ 0100.
2. Audit was performed to shoe the frequency of Fire Drills. Regulations were reviewed to assure compliance going forward.
3. Surveyor and Administrator discussed the importance of assure time of month changes every month. The time of day has to change every month. The surveyor also discussed the importance of clearing the COVID restriction time by the DHS office. Administrator and Maintenance will plan scheduled fire drills to capture a different time of day each month and to include drills during sleeping hours.
4. Administrator will audit fire drill log monthly to ensure that fire drill times vary each month and that sleeping hours are part of the rotation.

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented (████) - 08/28/2023)

## 182b - Prescription Medication

## 13. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

182b Prescription Medication (continued)

**Description of Violation**

Direct care staff member C completed the modified medication administration course on 7/14/23. The 2022 annual practicum was not completed.

Direct care staff member D's 2022 annual practicum does not include the 2 required medication administration observations.

Direct Care Staff Member E's initial medication administration course was completed 12/2/22. The required 4 medication administration observations were not completed as part of the initial training.

Staff C, D and E administer medications to residents.

**Plan of Correction**

Accept [REDACTED] - 08/18/2023)

1. For Direct Care staff member C The Administrator/ Train the Trainer completed the 2022 Annual Practicum was completed on 7/14/23 and 7/14/23 started the new medication training to be completed by 7/30/23.
  - a. Direct Care staff member D the administrator/Train the Trainer completed 2 required medication administration observations were completed 7/13/23.
  - b. Direct Care Staff Member E The administrator/Train the Trainer completed the medication observations when course was completed on 12/2/22. Re evaluated and observed on 7/13/23 and initialed and signed.
2. The Administrator completed an audit of med tech observations was completed on 7/17/2023 to ensure staff were up to date with required observations
3. Administrator and Med Trainer were educated regarding the importance of required scheduling of medication observations
4. Administrator will audit 5 staff records monthly to ensure that medication observations were completed timely.

Licensee's Proposed Overall Completion Date: 08/07/2023

Implemented [REDACTED] - 08/28/2023)

185a - Implement Storage Procedures

**14. 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 1's MAR indicates a blood sugar reading of [REDACTED] on [REDACTED] but there is no reading on the resident's glucometer on [REDACTED].

**Plan of Correction**

Accept [REDACTED] 08/18/2023)

1. Resident 1 had no ill effects from the missing accucheck results on 7/6/23
2. Residents with accucheck orders were reviewed by the administrator and license nurse to ensure that their glucometer results were accurately documented in the medication record.
3. The administrator provided Education to staff on 7/12/2023 regarding the importance of accucheck monitoring and the corresponding documentation.
4. Administrator will complete an audit for 3 residents with accucheck orders weekly for 4 weeks and then monthly for 3 months to be sure blood glucose results are being obtained and documented per physicians orders.

## 185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: 08/07/2023

Implemented (████) - 08/28/2023)

## 187d - Follow Prescriber's Orders

## 15. Requirements

2600.

187.d. The home shall follow the directions of the prescriber.

## Description of Violation

Resident 2 is prescribed ██████████ 1 drop for each eye at ██████████. The resident did not receive the medication at ██████ on ██████████

## Plan of Correction

Accept ██████ - 08/18/2023)

1. Resident 2 had no ill effects from not receiving the Gentle Tears on 7/11/23 at 9am.
2. The Administrator reviewed resident MAR's for the past 10 days to ensure that meds were given per physician order.
3. Administrator provided education on 7/12/2023 to medication Techs and LPN regarding the importance of administering medications per physician orders and as scheduled.
4. The Administrator will complete an audit of 3 staff members doing med pass weekly x 4 weeks and then monthly for 2 months to ensure that medications are given per physician orders.

Licensee's Proposed Overall Completion Date: 08/07/2023

Implemented (████) - 08/28/2023)