

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

October 18, 2023

[REDACTED], ADMINISTRATOR  
ALBRECHT INC  
1710 MAPLE AVENUE  
COAL TOWNSHIP, PA, 17866

RE: GUARDIAN ANGEL PERSONAL CARE  
HOME  
1710 MAPLE AVENUE  
COAL TOWNSHIP, PA, 17866  
LICENSE/COC#: 20208

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/08/2023 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: *GUARDIAN ANGEL PERSONAL CARE HOME* License #: *20208* License Expiration: *09/22/2023*  
 Address: *1710 MAPLE AVENUE, COAL TOWNSHIP, PA 17866*  
 County: *NORTHUMBERLAND* Region: *NORTHEAST*

**Administrator**

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

**Legal Entity**

Name: *ALBRECHT INC*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *06/25/1995* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *19* Waking Staff: *14*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal, Complaint* Exit Conference Date: *08/08/2023*

**Inspection Dates and Department Representative**

*08/08/2023 - On-Site:* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: *20* Residents Served: *19*

**Secured Dementia Care Unit**  
 In Home: *No* Area: Capacity: Residents Served:

**Hospice**  
 Current Residents: *0*

**Number of Residents Who:**  
 Receive Supplemental Security Income: *15* Are 60 Years of Age or Older: *17*  
 Diagnosed with Mental Illness: *7* Diagnosed with Intellectual Disability: *3*  
 Have Mobility Need: *0* Have Physical Disability: *0*

**Inspections / Reviews**

**08/08/2023 Full**  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/04/2023*

**09/12/2023 - POC Submission**  
 Submitted By: [REDACTED] Date Submitted: *10/17/2023*  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/18/2023*

Inspections / Reviews *(continued)*

09/22/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/17/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/28/2023

10/17/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/17/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/20/2023

10/18/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/17/2023

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

*The License inspection summary report dated 8/23/22 was posted on the refrigerator in the kitchen pantry where food is stored. The report was not posted in a public and conspicuous place as required.*

Plan of Correction

Accept (█ - 09/11/2023)

*Our inspection report has been posted in the same location for over 20 years. It was right outside the bathroom which all visitors have access too. I never wanted our home to look like an institution with bulletin boards all over. However, we have moved it to the dining room. Administrator will be responsible for future compliance. This allows residents, families and visitors to view our compliance and plans*

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (█ - 10/10/2023)

51 - Criminal Background Check

2. 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 was hired as a housekeeper in █. The home did not conduct a criminal background check on staff person A.*

Plan of Correction

Accept (█ - 09/11/2023)

*Staff person A is a volunteer house cleaner. We did have a background check but it was not put in the file. Administrator will be responsible for all staff and volunteers to have a background check and have it located in the file. This will ensure that staff & volunteers do not have a criminal background that would endanger the safety of our residents.*

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (█ - 10/10/2023)

65a - FS Orientation 1st Day

3. 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:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

65a FS Orientation 1st Day (continued)

- 5. The location and use of fire extinguishers.
- 6. Smoke detectors and fire alarms.
- 7. Telephone use and notification of emergency services.

Description of Violation

Staff person A was hired in [REDACTED] and did not receive training in the topics required by this regulation.

Plan of Correction

Accept [REDACTED] - 09/22/2023)

Staff member A is a volunteer. [REDACTED] was verbally trained but not formally. [REDACTED] has since been officially trained in all required fields. Administrator will be responsible for training all future staff & volunteers immediately so that they are ready & prepared to respond to all emergency situations. Staff A was Trained by administrator on 8/2/23. Administrator also checked all other staff trainings to ensure compliance.

Licensee's Proposed Overall Completion Date: 09/14/2023

Implemented ([REDACTED] - 10/10/2023)

65b - Rights/Abuse 40 Hours

4. 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.
- 2. Emergency medical plan.
- 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- 4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A was hired in [REDACTED] and did not receive training in the topics required by this regulation.

Plan of Correction

Accept [REDACTED] - 09/22/2023)

Staff member A was verbally oriented but not formally. [REDACTED] has now received full, required orientation. Administrator will be responsible for all future orientations of all staff and volunteers. This will ensure that all staff & volunteers will be knowledgeable with residents rights, mandated reporting, and procedures for responding to a medical emergency. Staff A was trained by Administrator on 8/2/23. All staff training was audited by administrator to ensure full compliance.

Licensee's Proposed Overall Completion Date: 09/14/2023

Implemented ([REDACTED] - 10/10/2023)

85a - Sanitary Conditions

5. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

The litter box located in the home's pantry had cat feces in it and needed to be cleaned out. During the morning walkthrough cat feces was observed on the kitchen floor in front of the litter box as well as in the litter box. Repeat violation from 8/23/22.

**85a - Sanitary Conditions (continued)**

**Plan of Correction**

Accept (█) - 09/12/2023)

*Litter box is cleaned daily and cleanings are documented. Cat was literally leaving the pantry as inspector entered. There was 1 fecal matter in the box & 1 fell out directly in front of the box, not in the kitchen. Administrator immediately cleaned it up off the floor & disposed of it. Staff is responsible for maintaining the litter box and future compliance & documentation will continue. Sanitary conditions are necessary to minimize risk of illness & infestations & provides a dignified living conditions for residents.*

**Licensee's Proposed Overall Completion Date: 08/31/2023**

Implemented (█) - 10/10/2023)

**102i - Soap Dispenser**

**6. Requirements**

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

**Description of Violation**

*A bar of soap was found in a 2nd floor shower.*

**Plan of Correction**

Accept (█) - 09/12/2023)

*Liquid soap dispensers are in every bathroom & are maintained. A resident forgot their personal bar in the shower. Administrator immediately removed it. Resident was verbally reminded to take their soap with them after a shower. Administrator constantly reminds and provides liquid soap for all residents. Staff was verbally educated on checking bathrooms for bar soaps during rounds. Administrator & staff will be responsible for future compliance & to ensure that personal hygiene is maintained.*

**Licensee's Proposed Overall Completion Date: 08/31/2023**

Implemented (█) - 10/10/2023)

**103e - Left Overs**

**7. Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

**Description of Violation**

*A plastic ice cream container was found in the resident refrigerator with sliced tomatoes in it. The container was not labeled with its contents and date the contents were placed in the refrigerator.*

*A plastic bag of frozen mac and cheese was stored in the standing freezer with no label indicating what it was and the date it was stored in the freezer.*

**Plan of Correction**

Accept (█) - 09/12/2023)

*The sliced tomatoes were from our garden and were going to be served as a side of tomato salad at the next meal. It was not a leftover & was just stored briefly before service. The mac & cheese was labeled as is all food in storage, however, the permanent marker was smeared off. Water resistant labels are used to mark food for storage. Hopefully they will work. We are open to better suggestions in this matter. In the meantime, staff will be responsible for maintaining future compliance and keeping labels on food to provide the identity of food items and*

103e - Left Overs (continued)

*the length of time food is stored, prevent cross contamination of food & the use of expired food items.*

**Licensee's Proposed Overall Completion Date: 08/31/2023**

**Implemented (█) - 10/10/2023)**

103f - Refrigerator/Freezer Temps

**8. 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**

*The thermometer found in the freezer indicated the temperature was 10 degrees.*

*The thermometer found in the refrigerator indicated the temperature was 50 degrees.*

*Both thermometers were checked multiple times.*

**Plan of Correction**

**Accept (█) - 09/12/2023)**

*A new refrigerator was purchased and thermometers were placed in both fridge & freezer. Administrator will be responsible for the proper performance of all appliances. This will ensure foods are stored at safe temperatures.*

**Licensee's Proposed Overall Completion Date: 08/31/2023**

**Implemented (█) - 10/18/2023)**

121a - Unobstructed Egress

**9. 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**

*During the initial walkthrough a chair was observed blocking the rear exit of the home.*

**Plan of Correction**

**Accept (█) - 09/22/2023)**

*The chair was partially in front of a back exit door in the therapy room. it was immediately moved during inspection. Staff was verbally reminded to check all exits during rounds & the therapists were verbally notified of the regulation and the therapy company was notified. Therapist rearranged the room to prevent future non compliance. Staff, administrator & therapist will be responsible for future compliance so that people can escape in an emergency situation.*

**Licensee's Proposed Overall Completion Date: 09/14/2023**

**Implemented (█) - 10/18/2023)**

132c - Fire Drill Records

**10. Requirements**

2600.

132c Fire Drill Records (continued)

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 dates of fire drills conducted in October 2022 and April 2023 were not recorded on the home's fire drill logs.

**Plan of Correction**

Accept (█ - 09/12/2023)

Dates were accidentally not documented for 2 separate months. After checking records, dates were corrected. Administrator will be responsible to ensure future compliance in order to identify & correct possible problems with evacuations and keep residents & staff safe.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (█ - 10/10/2023)

132e - Fire Drill Sleeping Hours

**11. Requirements**

2600.

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

**Description of Violation**

The home has not conducted sleeping hour drills every six months as required. The last sleeping hour drill was conducted more than 7 months ago on 10/26/22.

**Plan of Correction**

Accept (█ - 09/12/2023)

Fire drill was held at night but not during sleeping hours. A sleeping hour fire drill was held on 8/9/23 to be in compliance. Administrator will be responsible for future compliance and a sleeping hour drill will be held every 6 months. It is important to practice response & evacuation during sleeping hours because response times & actions are reduced.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (█ - 10/10/2023)

141b1 - Annual Medical Evaluation

**12. Requirements**

2600.

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

**Description of Violation**

Resident #1's Documentation of Medical Evaluation (DME) form was completed late for 2023. Resident #1 had DME forms completed on █ and █

**Plan of Correction**

Accept (█ - 09/22/2023)

Residents DME was late because █ refused to go for █ exam with █ guardian. I spoke with █ guardian and resident and it was agreed upon to switch to the house doctor. █ DME will be on time. Administrator will be responsible for future compliance. Accurate & updated DMEs are necessary in order to meet resident needs and to develop accurate support plans. Residents DME was completed on █ as stated in the violation.

Licensee's Proposed Overall Completion Date: 09/14/2023

141b1 Annual Medical Evaluation (continued)

Implemented ( ) - 10/10/2023)

162c Menus Posted

13. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home had only the current week's menu posted.

Plan of Correction

Accept ( ) - 09/12/2023)

Previous menu and current menu were posted Current menu was 5 days in advance. The following week menu was added to be in compliance. Admin asst is responsible for posting 2 weeks of menus. Compliance will ensure that residents will be able to plan their meals in advance & can arrange for an alternate meal if necessary.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented ( ) - 10/18/2023)

183c Refrigerated Meds Locked

14. Requirements

2600.

183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

An insulin pen belonging to resident #2 was found in the resident refrigerator unlocked and accessible to other residents.

Plan of Correction

Accept ( ) - 09/12/2023)

Container & lock were purchased by administrator for the insulin pen. Administrator will be responsible for future compliance. Refrigerated medications need to be locked to keep it safe from contamination, spillage, theft or misuse.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented ( ) - 10/10/2023)

183e Storing Medications

15. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

The insulin pen belonging to resident #3 was not labeled with the date it was opened for use.

Plan of Correction

Accept ( ) - 09/22/2023)

Pen was immediately dated. Administrator is responsible. Administrative asst was verbally educated by admin to ensure future compliance. This ensures that meds will be stored & used in a safe manner. Administrator will do

**183e Storing Medications (continued)**

random checks on the insulin storage to ensure compliance.

Licensee's Proposed Overall Completion Date: 09/14/2023

Implemented [REDACTED] - 10/10/2023)

**184a - Resident's Meds Labeled**

**16. Requirements**

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

**Description of Violation**

Resident #3 has a sliding scale order for [REDACTED] times daily with meals. The pharmacy label did not match the physician's order for the sliding scale. The pharmacy label states to take 1 unit of insulin if the blood sugar is 181 to 210; the physician's order is for 1 unit of insulin if the blood sugar is 146 to 175.

Resident #4 has a sliding scale order for [REDACTED] daily with meals. The pharmacy label did not match the physician's order for the sliding scale. The pharmacy label states to take 2 units of insulin if the blood sugar is 151 to 200; the physician's order is for 3 units of insulin if the blood sugar is 151 to 200.

The [REDACTED] inhaler for resident #5 was stored in the medication cart with no pharmacy label attached.

**Plan of Correction**

Accept [REDACTED] - 09/12/2023)

Sliding scale on MAR is printed small. A retyping of the scale was made to have easy reading. When the MARS were checked from 1 month to the next, the insulin order was checked but not the sliding scale & the MAR was printed wrong. The Doctor & the pharmacy was notified & the corrections were made. The inhaler was returned to its labeled box. Staff was verbally notified about keeping meds in their labeled boxes. Administrator is responsible for continued compliance. This reduces the chance that meds will be administered to the wrong resident or improperly.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [REDACTED] - 10/10/2023)

**187a - Medication Record**

**17. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

187a - Medication Record (continued)

**Description of Violation**

Resident #3 has a sliding scale order for [REDACTED] times daily with meals. The Medication Administration Record (MAR) did not match the physician's order for the sliding scale. The MAR states to take 1 unit of insulin if the blood sugar is 181 to 210; the physician's order is for 1 unit of insulin if the blood sugar is 146 to 175.

Resident #4 has a sliding scale order for [REDACTED] times daily with meals. The MAR did not match the physician's order for the sliding scale. The MAR states to take 2 units of insulin if the blood sugar is 151 to 200; the physician's order is for 3 units of insulin if the blood sugar is 151 to 200.

**Plan of Correction**

Accept [REDACTED] - 09/22/2023

Sliding scale on MAR is printed small. A retyping of the scale was made to have easy reading. When the MARS were checked from 1 month to the next, the insulin order was checked but not the sliding scale % the MAR was printed incorrectly, The Dr. & the pharmacy were notified by the administrator & the corrections were made on 8/8/23. Administrator will be responsible to ensure all future compliance.

Licensee's Proposed Overall Completion Date: 09/14/2023

Implemented [REDACTED] - 10/10/2023

225c - Additional Assessment

**19. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

**Description of Violation**

Resident #1's annual support plan for [REDACTED] was completed late. Resident #1 had support plans completed on [REDACTED] and [REDACTED].

**Plan of Correction**

Accept [REDACTED] - 09/22/2023

This was addressed in #12. Resident refused to go to the doctor with his guardian. DME was late which in turn caused support plan to be late. Discussion was had with admin, resident & guardian. It was decided to have resident switch to house Doctor to prevent future violations. Administrator will be responsible for future compliance so that residents needs will be addressed & met, Support plan was completed on [REDACTED] as stated in the violation.

Licensee's Proposed Overall Completion Date: 09/14/2023

Implemented [REDACTED] 10/10/2023

227d - Support Plan Medical/Dental

**20. Requirements**

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

227d Support Plan Medical/Dental (continued)

**Description of Violation**

Resident #7 had rails attached to their hospital bed. The resident's support plan dated [REDACTED] did not indicate what the resident's needs were in reference to the use of the bed rails.

**Plan of Correction**

Accept [REDACTED] - 09/22/2023)

The bed had upper quarter rails that came with it are not prohibited nor are they a restraint according to regulation on page 178 of the RCG. Resident is not inhibited on entering or exiting the bed. However, as a precaution to prevent possible injury, rails were lowered. Administrator will obtain documentation from physician if bed rails are necessary & it will be documented in the support plan. I feel that this is not a violation because it was only upper quarter rails & they didn't prohibit resident in any way from exiting the bed. Administrator, accompanied by the resident, lowered the bed rail and they are no longer in use. In the future, if beds come with rails, they will either immediately be lowered by administrator or documentation will be obtained from Doctor if they are necessary. This will ensure safety for all residents & prohibit potential injury.

Licensee's Proposed Overall Completion Date: 09/14/2023

Implemented [REDACTED] - 10/10/2023)

251b - Record Entries Legible

**21. Requirements**

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

**Description of Violation**

Resident #1's DME dated [REDACTED] has white out on page 2 under section 3 medical information.

**Plan of Correction**

Accept [REDACTED] - 09/12/2023)

Our staff never uses whiteout on a legal document. The whiteout was used by the doctors office The doctor was notified that this is not allowed and staff were verbally told to not accept any documents with whiteout, administrator is responsible to ensure future compliance. This is to ensure that all information is accurate, detailed & unaltered.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [REDACTED] - 10/10/2023)