

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

May 14, 2024

[REDACTED]  
EMBASSY DARLINGTON LLC  
[REDACTED]

RE: LAKEVIEW PERSONAL CARE  
498 LISBON ROAD  
DARLINGTON, PA, 16115  
LICENSE/COC#: 45161

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/12/2023 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,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: LAKEVIEW PERSONAL CARE License #: 45161 License Expiration: 06/21/2023  
 Address: 498 LISBON ROAD, DARLINGTON, PA 16115  
 County: BEAVER Region: WESTERN

**Administrator**

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

**Legal Entity**

Name: EMBASSY DARLINGTON LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 03/22/1993 Issued By: L&I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 62 Waking Staff: 47

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Monitoring Exit Conference Date: 09/12/2023

**Inspection Dates and Department Representative**

09/12/2023 - On-Site [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: 92 Residents Served: 55

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

**Hospice**  
 Current Residents: 6

**Number of Residents Who:**  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 55  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 7 Have Physical Disability: 1

**Inspections / Reviews**

09/12/2023 - Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/02/2023

10/11/2023 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 10/05/2023  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/18/2023

Inspections / Reviews *(continued)*

03/27/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/29/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/05/2024

05/14/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2024

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

On 9/12/23, Direct care staff person A, hired 2/21/23, did not have a PA State Police criminal background history check completed or on record.

On 9/12/23 Direct care staff person B, hired 5/14/23, did not have a PA State Police criminal background history check completed or on record.

Plan of Correction

Accept [REDACTED] - 11/29/2023)

On 9/15/23 Direct Care Staff A &B's criminal background checks were resubmitted. They have both been returned to the community.

Beginning 9/15/23 administrator will review each new hire with the New Business Office manager to ensure that the Criminal Background Checks are being completed appropriately.

All Background checks are complete for all staff.

Licensee's Proposed Overall Completion Date: 10/20/2023

Implemented [REDACTED] - 05/14/2024)

65a - FS Orientation 1st Day

2. 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 person B, hired 5/14/23, did not receive any first day or prior training related to 2600.65a

Plan of Correction

Accept [REDACTED] - 11/29/2023)

Beginning 9/13/23 the new Business Office Manager [REDACTED] has been trained/instructed by the Administrator [REDACTED] that all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness prior to or on their first day of work.

The Administrator [REDACTED], will review all new hire paperwork monthly to ensure that all training for new hires has been completed properly.

The Administrator [REDACTED], Will keep a monthly tracking record of all new hires, to ensure that all trainings have been completed.

Proposed Overall Completion Date: 10/20/2023

65a - FS Orientation 1st Day (continued)

Licensee's Proposed Overall Completion Date: 10/20/2023

Implemented [redacted] - 05/14/2024)

65b - Rights/Abuse 40 Hours

3. 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:

Description of Violation

On 9/12/23, Direct care staff person B, hired 5/14/23 and has worked unsupervised in the home for 652 hours since the date of hire. However, the staff person did not receive training as related to 2600.65b prior to the completion of 40 hours.

Plan of Correction

Accept [redacted] - 11/29/2023)

Staff person B was a temporary summer worker and is not longer employed by Lakeview.

Beginning 9/13/23 the new Business Office Manager Alaina Deluca has been trained/instructed by the Administrator Eric Trehar that so new staff is to work the floor with residents until all 40 hours of training as required in 2600.65b has been completed.

The Administrator [redacted], will review all new hire paperwork monthly to ensure that all training for new hires has been completed properly.

The Administrator [redacted], Will keep a tracking record monthly to ensure that all trainings have been completed.

Proposed Overall Completion Date: 10/20/2023

Licensee's Proposed Overall Completion Date: 10/20/2023

Implemented [redacted] - 05/14/2024)

85d - Trash Receptacles

4. 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

The lid to the trash can was missing in the common bathroom by the dining area. Trash can was full.

Repeat Violation: 2/1/22

Plan of Correction

Accept [redacted] - 03/27/2024)

On 9/13/23 the Administrator [redacted], purchased new trash receptacles with lids for all community restrooms.

The Maintenance Director will perform a weekly inspection of each restroom to ensure that each receptacle is in

**85d - Trash Receptacles (continued)**

good working condition and replace any worn or broken receptacles.

Proposed Overall Completion Date: 10/20/2023

Licensee's Proposed Overall Completion Date: 10/20/2023

Implemented [REDACTED] - 05/14/2024)

**95 - Furniture and Equipment****5. Requirements**

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

**Description of Violation**

The paper towel dispenser was not operating in the common bathroom by the dining area.

**Plan of Correction**

Accept [REDACTED] - 03/27/2024)

On 9/13/23 the Maintenance Director [REDACTED] replaced the batteries in the restroom paper towel dispenser to ensure that it is good working condition.

Beginning 9/13/23 the Maintenance Director will work with the housekeeping department to ensure that all paper towel dispensers are in good working order and to replace or repair any units that are broken.

The Maintenance Director will perform a weekly check of all Paper Towel dispensers to ensure that they are all in good working order. He will keep a weekly check sheet.

Proposed Overall Completion Date: 10/20/2023

Licensee's Proposed Overall Completion Date: 10/20/2023

Implemented [REDACTED] - 05/14/2024)

**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**

There was no soap in the soap dispenser in the common bathroom by the dining area.

**Plan of Correction**

Accept [REDACTED] - 03/27/2024)

On 9/13/23 the Maintenance Director Bob Turkovich replaced the batteries in the restroom soap dispenser to

**102i - Soap Dispenser (continued)**

*ensure that it is good working condition.*

*Beginning 9/13/23 the Maintenance Director will work with the housekeeping department to ensure that all soap dispensers are in good working order and to replace or repair any units that are broken.*

*The Maintenance Director will perform a weekly check of all soap dispensers to ensure that they are all in good working order. He will keep a weekly check sheet.*

*Proposed Overall Completion Date: 10/20/2023*

**Licensee's Proposed Overall Completion Date: 10/20/2023**

**Implemented [REDACTED] 05/14/2024)**

**103f - Refrigerator/Freezer Temps****7. 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**

*There was no thermometer in the juice/milk chest cooler.*

*Repeat Violation: 2/1/22*

**Plan of Correction**

**Accept [REDACTED] - 11/29/2023)**

*On 9/13/23 the Dining Services Director placed a new thermometer in the juice/milk/chest cooler while the state inspector was present.*

*Beginning 9/13/23 the dietary staff have been directed to ensure that all thermometers are present in each cooler/freezer in the kitchen and are working properly.*

*Beginning 9/13/23 the Dietary Staff are directed to initial a sheet daily along with the temperature that the thermometer is present and recording the temperature.*

**Licensee's Proposed Overall Completion Date: 10/20/2023**

**Implemented [REDACTED] - 05/14/2024)**

**103g - Storing Food**

8. Requirements

2600.  
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There was a unsealed bag of fish fillets and an unsealed bag of frozen biscuits in the white Frigidaire stand up freezer in the kitchen.

Plan of Correction

Directed [REDACTED] - 03/27/2024)

On 9/13/23 all dietary staff were re-educated by the Dining Services Director Jennifer Placer about the importance of dating and storing all food items along with ensuring that all food items are properly sealed.

Beginning 9/13/23 the Dietary Shift Manager will inspect all refrigerating units to ensure that all items are date and sealed properly

**Directed:** Inspection of refrigeration units by dietary shift managers will be completed at least weekly beginning 4/1/24 and documentation will be submitted to the Department. [REDACTED] 3/27/24

A sign off sheet will be kept.

Proposed Overall Completion Date: 10/20/2023

Directed Completion Date: 04/01/2024

Implemented [REDACTED] - 05/14/2024)

132d - Evacuation

9. Requirements

2600.  
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's safe evacuation time is 5 minutes 48 seconds. However, records indicated that the home exceeded this safe evacuation time during the fire drills conducted on 5/25/23 at 7:30 p.m. with an evacuation time of 6 minutes 20 seconds, 6/14/23 at 4:30 a.m. with an evacuation time of 8 minutes 42 seconds, 8/19/23 at 12:00 a.m. with an evacuation time of 8 minutes 25 seconds,

Plan of Correction

Directed [REDACTED] - 11/29/2023)

On 9/14/23 the Maintenance Director [REDACTED] discussed the proper evacuation times with the Ohioville Volunteer Fire Department, Fire Chief.

On 9/14/23 the Administrator, [REDACTED] and the Maintenance Director, [REDACTED] provided a in-service for all staff of the expectation of the evacuation time is and on how to evacuate the community in a more timely and safe manner.

Proposed Overall Completion Date: 10/20/2023

132d - Evacuation (continued)

**Directed:** Beginning 3/31/24, the administrator or designated staff person will review all previous month fire drills and evacuation times monthly to ensure all residents evacuated within the designated safe evacuation time and make adjustments to staffing as needed to ensure residents can safely evacuate at all times. Documentation will be submitted to the Department. [REDACTED] 3/27/24

Directed Completion Date: 04/01/2024

Implemented ([REDACTED] - 05/14/2024)

132f - Alternate Exit Routes

10. Requirements

2600.  
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home's fire drill record indicated that the front door, rear deck and downstairs dining room exits were used as the exit route during the fire drills conducted on 6/14/23, 7/20/23, and 8/18/23.

Plan of Correction

Directed ([REDACTED] 11/29/2023)

On 9/13/23 the Administrator [REDACTED] met with the Maintenance Director [REDACTED] to discuss the importance of utilizing alternate exits during fire drills.

Beginning 9/13/23 the Administrator, [REDACTED] will be present at all fire drills to ensure utilization of alternate exits are being utilized.

The alternative exits used will be tracked on the fire drill record.

Proposed Overall Completion Date: 10/20/2023

**Directed:** Beginning 3/31/24, the administrator or designated staff person will review all previous month fire drills and monthly to ensure all alternate exits are used and documented on the fire drill record for the month. Documentation will be submitted to the Department. [REDACTED] 3/27/24

Directed Completion Date: 04/01/2024

Implemented ([REDACTED] - 05/14/2024)

141b1 - Annual Medical Evaluation

11. Requirements

2600.  
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [REDACTED] annual medical evaluation was completed on 5/8/23. However the previous evaluation was conducted on 4/8/21.

Resident [REDACTED] most recent annual medical evaluation was completed on 6/16/22.

Repeat Violation: 4/18/22, 2/1/22

## 141b1 - Annual Medical Evaluation (continued)

**Plan of Correction****Accept** [REDACTED] **11/29/2023)**

On 9/14/23 The Administrator [REDACTED] reviewed all resident charts to ensure that all annual medical evaluations are completed.

Beginning 9/14/23 the new Wellness Director and the Administrator will be responsible for ensuring that all DME's are completed within the guidelines set by the DHS.

A tickler system has been in place to help ensure that these are being completed on the annual date of the residents physician filling them out.

Resident [REDACTED] and [REDACTED]'s DME are completed and up to date.

A tickler system is being utilized monthly to ensure that all DME's are current for each resident monthly. On 9/14/23 that administrator will complete a monthly audit of the tickler system to ensure that the DME's continue to be updated and current.

Licensee's Proposed Overall Completion Date: 10/20/2023

**Implemented** [REDACTED] **- 05/14/2024)**

## 185a - Implement Storage Procedures

**12. 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 [REDACTED] [REDACTED] was not calibrated to correct date and time.

Resident [REDACTED] [REDACTED] was not calibrated to correct date and time.

Resident [REDACTED] is prescribed [REDACTED] – take 1 tablet by mouth every six hours as needed for anxiety. However, this medication was not available in the home.

**Plan of Correction****Accept** [REDACTED] **- 11/29/2023)**

On 9/13/23 resident [REDACTED] and [REDACTED] were recalibrated by the community pharmacy (Hometown Pharmacy) to ensure that the community is getting proper readings.

Beginning 9/14/23 the communities pharmacy will recheck the glucometers monthly to ensure that they are properly calculating and on the correct dates.

On 9/14/23 Resident [REDACTED] lorazepam was delivered to the community. The Supervisor [REDACTED] was in contact with the residents pharmacy and alerted them that his medication was not delivered to the community.

On 9/14/23 the Administrator [REDACTED] met with the supervisors about ensuring that all medications are present

**185a - Implement Storage Procedures (continued)**

*and available for residents at all times.*

*They have been instructed to alert the administrator and the new wellness director (when hired) whenever there is a concern that a medication is running low or is not available so that they can make arrangements to get the medications delivered.*

**Licensee's Proposed Overall Completion Date: 10/20/2023**

**Implemented [REDACTED] - 05/14/2024)**