pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **CRYSTAL WATERS, INC.**
LEGAL ENTITY

To operate **CRYSTAL WATERS**
NAME OF FACILITY OR AGENCY

Located at **4639 ROUTE 119,HWY NORTH, HOME, PA 15747**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **66**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **February 9, 2024** until **August 9, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **427651**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: FEBRUARY 9, 2024

[redacted], President
Crystal Waters, Inc.
4639 Route 119, Highway North
Home, Pennsylvania 15747

RE: Crystal Waters
License/COC #: 427651

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 28, 2023, and October 4, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from February 9, 2024 to August 9, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals,

Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *CRYSTAL WATERS* **License #:** *42765* **License Expiration:** *09/18/2023*

Address: *4639 ROUTE 119,HWY NORTH, HOME, PA 15747*

County: *INDIANA* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *CRYSTAL WATERS, INC.*

Address: *4639 ROUTE 119,HWY NORTH, HOME, PA, 15747*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/07/1998* **Issued By:** *L&I*

Type: *I-1* **Date:** *12/21/2010* **Issued By:** *Rayne Township*

Staffing Hours

Resident Support Staff: *52* **Total Daily Staff:** *110* **Waking Staff:** *83*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *06/28/2023*

Inspection Dates and Department Representative

06/28/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *50*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *50*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *8* **Have Physical Disability:** *1*

Inspections / Reviews

06/28/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/22/2023*

07/27/2023 - POC Submission

Submitted By: [redacted]*hry* **Date Submitted:** *08/02/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/03/2023*

07/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/02/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/01/2023*

01/31/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/02/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted]/23, between 7:00 p.m., and 8:00 p.m., staff member A reported to staff member B that [redacted] told resident #1 to "get the [redacted] up" for [redacted] shower. However, this incident was not reported to Protective Services.

Plan of Correction ***Accept[redacted] - 07/27/2023)***

Staff Member A was terminated from Crystal Waters PCH on [redacted]23 by facility administrator.

Staff member A's first night of orientation was [redacted]23 with facility administrator, the same night as the incident. Staff Member B who witnessed the treatment notified administrator at 11pm on [redacted]/23 after Staff member A had left the facility. [redacted] 06/28/23 during the annual inspection, the event was investigated by state inspectors and staff member A was terminated from Crystal waters on [redacted]/23 by facility administrator in all capacities.

Facility Administrator, also reported the abuse to the department of state and older adult protective services on [redacted]/23 at 6 pm within the 24 hour time frame requirement.

Staff members were educated on resident rights and treatment of residents during staff meeting on 07/12/23 by facility administrator and RN.

Staff members educated on immediate reporting of abuse/neglect at staff meeting held on 07/12/13 by facility administrator and registered nurse.

Staff members will have annual training on mandated reporting/residents rights/ and treatment of residents by facility administrator and registered nurse.

Facility Administrator developed and implemented plan on 07/01/23 that will ensure that all reports of abuse/neglect are investigated and reported immediately upon discovery. This will be overseen by facility administrator.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Not Implemented[redacted] - 11/29/2023)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted]/23, between 7:00 p.m., and 8:00 p.m., Staff member A told staff member B that [redacted] stated to resident #1 to

15b - Supervisor Plan (continued)

"get the [redacted] up" for [redacted] shower. However, staff member A continued providing direct care services to resident until 10:45 p.m.

Plan of Correction ***Accept [redacted] 07/27/2023)***

Staff Member A was terminated from Crystal Waters PCH on [redacted]/23 by facility administrator.

Staff member A's first night of orientation was [redacted]/23 with facility administrator, the same night as the incident. Staff Member B who witnessed the treatment notified administrator at 11pm on [redacted]/23 after Staff member A had left the facility. [redacted] 06/28/23 during the annual inspection, the event was investigated by state inspectors and staff member A was terminated from Crystal waters on [redacted]/23 by facility administrator in all capacities.

Facility Administrator, also reported the abuse to the department of state and older adult protective services on [redacted]/23 at 6 pm within the 24 hour time frame requirement.

Staff members were educated on resident rights and treatment of residents during staff meeting on 07/12/23 by facility administrator and RN.

Staff members educated on immediate reporting of abuse/neglect at staff meeting held on 07/12/13 by facility administrator and registered nurse.

Facility administrator developed and implemented plan on 07/01/23 that will ensure Staff members will have annual training on mandated reporting/residents rights/ and treatment of residents by facility administrator and registered nurse.
Facility Administrator will ensure that all reports of abuse/neglect are investigated and reported immediately upon discovery.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

42c - Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted]/23, between 7:00 p.m., and 8:00 p.m., staff member A told resident #1 to "get the [redacted] up" for [redacted] shower.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Staff Member A was terminated from Crystal Waters PCH on [redacted]/23 by facility administrator.

Staff member A's first night of orientation was [redacted]/23 with facility administrator, the same night as the incident.

Staff Member B who witnessed the treatment notified administrator at 11pm on [redacted]/23 after Staff member A had left the facility. [redacted] 06/28/23 during the annual inspection, the event was investigated by state inspectors and staff member A was terminated from Crystal waters on [redacted]/23 by facility administrator in all capacities.

42c - Treatment of Residents (continued)

Facility Administrator, also reported the abuse to the department of state and older adult protective services on [redacted]/23 at 6 pm within the 24 hour time frame requirement.

Staff members were educated on resident rights and treatment of residents during staff meeting on 07/12/23 by facility administrator and RN.

Staff members educated on immediate reporting of abuse/neglect at staff meeting held on 07/12/13 by facility administrator and registered nurse.

Facility administrator developed and implemented plan on 07/01/23 that will ensure Staff members will have annual training on mandated reporting/residents rights/ and treatment of residents by facility administrator and registered nurse.

Facility administrator developed and implemented plan on 07/01/23 that will ensure that all reports of abuse/neglect are investigated and reported immediately upon discovery. Administrator, will ensure that all residents are treated with dignity and respect by all staff members at all times.
Facility administrator has developed and implemented Annual Training on 07/01/23 regarding abuse/neglect/treatment of residents/right rights/ and mandated reporting and will be overseen by facility administrator and registered nurse.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented ([redacted] - 11/29/2023)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A's first day of hire was [redacted]/23; however, the home did not have documentation of completion of high school diploma, General Equivalency Diploma, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Staff person A was orienting as a direct care staff on [redacted]/23 under direct supervision of administrator and/or direct care staff at all times. [redacted] was initially hired on [redacted]1/23 as ancillary staff.

Staff Person A Just graduated from [redacted] Highschool on [redacted]/23 and had not received [redacted] diploma from

54a - Direct Care Staff (continued)

the school yet.

[redacted]*/23 was her first day of orientation with direct care staff, and was terminated on* [redacted]*/23 by facility administrator.*

Staff member A was asked by facility administrator to provide documentation on [redacted]*/23, however, since being terminated on* [redacted]*/23 by facility administrator, has not returned to facility with requested diploma.*
Facility administrator developed and implemented plan on 07/01/23 that:
Facility Administrator, will ensure that all new direct care staff employees have high school diploma, GED, or active registry on the PA nurse registry prior to first day of employment. These documents will be obtained by facility administrator prior to or on first day of employment for all new staff.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented ([redacted] - 11/29/2023)

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 person A's first day of hire was [redacted]*/23. However, the staff person did not receive initial fire safety and emergency procedure training until* [redacted]*/23.*

Plan of Correction ***Accept ([redacted] - 07/27/2023)***

Staff member A was initially hired as ancillary staff on [redacted]*/23 for kitchen,* [redacted] *worked 2 hours dishwashing during* [redacted] *first week.*

[redacted] *was fully educated on fire safety and emergency procedure training on* [redacted] *first full shift on* [redacted]*/23 by facility administrator.*

Facility administrator has implemented plan on 07/01/23 to have all new employees trained in fire safety and emergency procedure training on the first day of employment by the facility administrator.

Facility Administrator has developed and implemented a plan on 07/01/23 to ensure that all new staff members have fire safety and emergency procedure training on the first day of employment by the facility administrator.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

65d - Initial Direct Care Training

6. Requirements

2600.

65d - Initial Direct Care Training *(continued)*

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

Description of Violation

Direct care staff person A hired on [redacted]/23, began providing activities of daily living services on [redacted]/23, to multiple residents to include resident #1 and resident #2. However, the home did not have documentation of successful completion and passing of the Department – approved direct care training course and passing the competency test.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Direct care staff person A was hired as ancillary staff for the kitchen on [redacted]23 and worked 2 hours a day as a dishwasher. [redacted] then requested to start training as a direct care staff on [redacted]/23. [redacted] was supervised at all times either by administrator or other direct care staff.

[redacted] was terminated from Crystal waters on [redacted]/23 by facility administrator and has never provided any further documentation to our facility as requested.

Facility Administrator has developed and implemented a plan on 07/01/23 to ensure that all new employees complete the department approved direct care training course and competency test prior to providing any unsupervised ADL services. This will be overseen by facility administrator.

Facility administrator developed and implemented plan on 07/01/23 that will continue to ensure that all new employees have required Training that includes a demonstration of job duties, followed by supervised practice before providing unsupervised care. This will be overseen by the facility administrator.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct Care staff person C hired [redacted]20, did not complete 12 hours of annual training during the 1/1/22, to 12/31/22, training year.

Direct Care staff person D hired [redacted]/20, did not complete 12 hours of annual training during the 1/1/22, to 12/31/22, training year.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Direct care staff person C and D have completed the 12 hours of annual training on 07/05/23 and 07/06/23 by facility registered nurse and will continue with monthly trainings as scheduled. Facility administrator to ensure compliance with monthly trainings.

65e - 12 Hours Annual Training (continued)

Facility administrator developed and implemented new education plan on 07/01/23 to ensure that all employees remain current with their required trainings.

Administrator developed and implemented plan on 07/01/23 that will ensure that all trainings on every employee are completed the first Monday of each month for the previous month's education. This will be overseen by facility administrator.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff person D, hired [redacted]/20, did not complete :2600.65F training during the 1/1/22, to 12/31/23, annual training year.

Plan of Correction ***Accept ([redacted] - 07/27/2023)***

DCS D completed the 2600.65F training on 07/12/23 as required by education with facility administrator.

Facility administrator developed and implemented a staff education plan to include the 2600.65F training on 07/01/23.

Facility Administrator will ensure that all staff members have completed the annual training according to the education calendar each year. 2600.665F training was added to the staff education plan calendar on 07/01/23.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

65g - Annual Training Content

9. 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:

Description of Violation

Direct care staff person D, hired [redacted]/20, did not complete :2600.65G training during the 1/1/22, to 12/31/23, annual training year.

Direct care staff person E, hired [redacted]/12, did not complete training in the following: Fire safety by a fire safety expert or staff trained by FSE, Emergency preparedness procedures, Older Adult Protective Services Act (OAPSA) and falls and accident prevention as indicated in 2600.65G.

Direct care staff person C, hired [redacted]/20, did not complete training in the following: Fire safety by a fire safety expert or staff trained by FSE, Emergency preparedness procedures, Older Adult Protective Services Act (OAPSA) and

65g - Annual Training Content (continued)

Falls and Accident Prevention as indicated in 2600.65G

Plan of Correction ***Accept [redacted] - 07/27/2023)***

DCS D, E, and C have completed all required training on 07/12/2023 educated by facility administrator.

Facility administrator developed and implemented a new education plan to include 2600.65G training on 07/01/2023

Administrator developed and implemented a plan on 07/01/23 that will ensure that all staff have completed all required annual training. Plan will be overseen by administrator. 2600.65G training has been added to the annual staff education plan calendar on 07/01/23. Administrator will ensure that all staff members have completed this training yearly.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

66a - Staff Training Plan

10. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for the calendar year of 2023.

Plan of Correction ***Accept [redacted] 07/27/2023)***

Education plan was developed and implemented on 07/01/23 by facility administrator to include all required education.

Staff have been educated on education plan at staff meeting on 07/12/23 by facility administrator.

Administrator, will ensure that all staff has completed monthly training on the first Monday of every month for the previous month as outlined by education plan implemented on 07/01/23.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

82c - Locking Poisonous Materials

11. 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

At 11:35 a.m., there was a 1/5 full container of Ready To Use No Rinse Sanitizer with the warning of "keep out of reach of children caution" and " for medical emergency call 24-hour emergency response number" in the common bathroom located on the home's patio level. However, multiple residents residing on the patio level of the home are

82c - Locking Poisonous Materials (continued)

unsafe around poisons.

Plan of Correction ***Directed [redacted] - 07/27/2023)***

Poisonous material was immediately removed on 06/28/23 at discovery and locked in cleaning cart by facility administrator .

Staff educated at staff meeting held on 07/12/23 that 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. Education provided by Facility Administrator.

Head of housekeeping, to check every Monday that all poison materials are locked away and accounted for at all times.

Directed: *Beginning 8/1/23 head of housekeeping, to check every Monday that all poison materials are locked away and accounted for at all times.* [redacted] ***7/27/23***

Directed Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

85b - Infestation

12. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

At 10:53 a.m., there was approximately a half dozen fruit flies in resident #3's bathroom. There was also approximately a half dozen fruit flies on/near the resident's bedside dresser that were on multiple pieces of uncovered half eaten pieces of chocolate covered pretzels.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Resident and staff education on cleanliness on the day of inspection on 06/28/23 by facility administrator. Beside dresser was cleaned by head of housekeeping and fruit flies were removed on 06/29/23.

Staff educated at staff meeting on 07/12/23 regarding fruit flies and cleanliness by facility administrator and head of housekeeping.

Head of housekeeping developed and implemented plan on 07/01/23 to monitor weekly on Mondays to ensure room is kept clean of uneaten food to prevent re-infestation of fruit flies.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

85d - Trash Receptacles

13. Requirements

2600.

85d - Trash Receptacles *(continued)*

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

At 10:56 a.m., there was an uncovered plastic trash can 3/4 full of refuse in resident #3 and #4's bathroom.

At 11:28 a.m., there was an uncovered black plastic garbage can 3/4 full black of refuse that had no lid on it in the common bathroom located on the patio level of the home.

Repeat Violation: 5/24/22 et. al

Plan of Correction ***Accept (- 07/27/2023)***

Garbage can lids were immediately replaced upon discovery on 06/28/23 by head of maintenance, as they were sitting beside or behind the garbage cans.

Staff educated that Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents at staff meeting on 07/12/23 by facility administrator.

Head of housekeeping developed and implemented plan on 07/01/23 to ensure compliance with garbage can lids every Monday.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented - 11/29/2023)

86b - Bathroom

14. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

At 10:50 a.m., the bathroom fan in resident room #2's bathroom was not operational. The bathroom had no window.

At 11:20 a.m., the bathroom fan in resident room #1's bathroom was not operational. The bathroom had no window.

Plan of Correction ***Accept (- 07/27/2023)***

Head of maintenance, repaired and cleaned fans of resident #1 and #2 bathrooms on 07/01/23.

Head of maintenance developed and implemented plan on 07/01/23 to clean and check bathroom fans on the first friday of every month.

Staff was educated by head of maintenance at staff meeting on 07/12/23 to notify maintenance with any building issues immediately upon discovery to be repaired by head of maintenance.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented - 11/29/2023)

92 - Windows

15. Requirements

92 - Windows *(continued)*

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

The left window of the side-by-side double window next to resident #5's bed had no screen in it. The screen was on the floor.

Plan of Correction ***Accept (- 07/27/2023)***

Resident #5's screen was immediately replaced upon discovery on 06/28/23 by head of maintenance as it was sitting below the window. Resident and staff educated on window and screen requirement on 06/28/23 by head of maintenance.

Staff educated at staff meeting on 07/12/23 by head of maintenance on window and screen requirements.

Administrator, developed and implemented plan on 07/01/23 to check the first friday of every month to ensure that all screens are in good repair and working condition by facility administrator.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Not Implemented - 11/29/2023)

101j7 - Lighting/Operable Lamp

16. 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

At 11:09 a.m., resident #5 did not have a source of bedside light that could be turned on/off at bedside. The resident's lamp was not plugged into the wall.

At 10:45 a.m., resident #6 did not have access to a source of bed side light that could be turned on/off at bedside. The lamp had no light bulb in it.

Plan of Correction ***Accept - 07/27/2023)***

Resident #5 lamp was immediately plugged back into the wall upon discovery during inspection on 06/28/23 by head of maintenance.
Resident #6 light bulb was immediately replaced upon discovery during inspection on 06/28/23 by head of maintenance.

Staff educated at staff meeting on 07/12/23 to ensure beside lights are operable at all times by head of maintenance.

Administrator developed and implemented plan on 07/01/23 to check rooms for operable beside lamps monthly on the first Friday of every month by facility administrator.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Not Implemented (- 11/29/2023)

103e - Left Overs

17. 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

At 11:40 a.m., there was an opened and partially used package of Udi gluten free blueberry muffins without a date on it in the home's walk-in refrigerator.

Plan of Correction ***Accept (- 07/27/2023)***

Muffins were immediately removed from refrigerator and thrown away at time of discovery by head of dietary on 06/28/23 during inspection.

Staff educated at staff meeting on 07/12/23 regarding dating and labeling of left over foods by head of dietary.

Head of dietary, developed and implemented a plan on 07/01/23 to ensure that food is labeled weekly on Monday's and to discard if open and unlabeled by head of kitchen.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented (- 11/29/2023)

103f - Refrigerator/Freezer Temps

18. 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

At 11:25 a.m., there was no thermometer in the white chest freezer located approximately 8 feet from the non-working walk-in freezer.

At 11:48 a.m., there was no thermometer in the freezer chest located in the dry food storage area.

Repeat Violation: 5/24/22 et. al

Plan of Correction ***Accept - 07/27/2023)***

Thermometers in both freezers had fallen to bottom of freezer and was found under food after inspection.

Thermometers were replaced at time of inspection on 06/28/23 and zip tied to ensure that they stay in place by head of maintenance.

Staff educated at staff meeting on 07/12/23 to ensure that thermometers are in place during daily freezer temperature checks by head of dietary.

Head of dietary developed and implemented a plan on 07/01/23 to check for thermometer placement weekly on Mondays.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented - 11/29/2023)

127a - Portable Space Heaters

19. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

At 11:05 a.m., there was a small portable black space heater on resident #7's private bathroom floor.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Resident was immediately educated on dangers and policy of portable space heater upon discovery on 06/28/23 by facility administrator. Space heater was removed from residents room and given back to family member on 06/28/23 by facility administrator.

Staff educated at staff meeting on 07/12/23 regarding space heaters and to immediately notify administrator if one is observed. Education provided by Facility administrator.

Administrator, developed and implemented a plan on 07/01/23 to check rooms the first Friday of every month to ensure that no space heaters are in facility.
Administrator, developed and implemented a plan on 07/01/23 that will review with resident and family at time of admission that space heaters are prohibited.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Not Implemented ([redacted] 11/29/2023)

144b - Policy on Smoking

20. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The home's smoking policy indicates smoking is allowed only in the following areas,15 feet away from the front entrance under the patio, on the lower patio level and in personal vehicles in the parking lot, However, there was a coffee can of approximately 30 cigarette butts at the exit to the large walk-in freezer.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Homes smoking policy was updated to include smoking area on the back porch on 07/01/23 by facility administrator.

Coffee can removed and replaced with "butt hut" on 07/01/23 by head of maintenance.

Staff and residents given written notice that smoking policy has changed on 07/01/23 by facility administrator.

Staff re-educated at staff meeting on 07/12/23 regarding smoking policy by facility administrator.

Administrator developed and implemented plan on 07/01/23 to ensure that staff/residents are following smoking policy daily.

144b - Policy on Smoking (continued)

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] 11/29/2023)

183b - Meds and Syringes Locked

21. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 4:38 p.m., the first of three resident med carts in the resident dining hall containing multiple resident's medications to include resident #8's medications were unlocked, unattended and accessible to approximately 25 residents.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Staff was immediately educated by facility administrator on 06/28/23 upon discovery and med carts were locked immediately on 06/28/23 by facility administrator.

All medication technicians were re-educated at staff meeting on 07/12/23 to lock medication carts/room at all times and to not leave keys unattended by head of medication training RN.

mediation trainer developed and implemented plan on 07/01/23 to continue to remind staff weekly of policy regarding locking and storage of medication cart/keys/room. This will be completed by head of med training RN

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

183d - Prescription Current

22. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

The basement medication cart contained Benzonatate 100mg capsule for resident #7 however, the order expired on 4/16/23.

At 2:52 pm the home's first-aid kit in the office area of the home contained 325 mg aspirin tablet expiration 01/2022 and Triple Antibiotic ointment expired 08/2019.

Plan of Correction ***Accept ([redacted] 07/27/2023)***

Medications from the first aid kit and basement medication cart above were immediately removed and discarded upon discovery on 06/28/23 by facility administrator.

/Medication technicians were re-educated at staff meeting on 07/12/23 to remove any medications from carts that do not have a current order by head of medication training registered nurse.

183d - Prescription Current (continued)

Head of mediation training, developed and implemented a plan on 07/01/23 to check medication carts every Friday to ensure that al medications in cart have current order. This will be completed by head of medication training registered nurse.

Medication trainer Developed and implemented plan on 07/01/23 that will check first aid kit the first Friday of every month for expired medications.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

184a - Resident's Meds Labeled

23. Requirements

2600.
184.a.4The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #8 is prescribed 22 units Toujeo of Solostar subcutaneous injection in the morning; however, the medication pharmacy label indicates 30 units.

Resident #8 is prescribed 2 X 325 mg tablet by mouth twice daily as needed for pain; however, the medication label indicates twice daily for arthritis. And another indicates three time per day as needed.

Resident #8 is prescribed 500 mg Metformin tablet by mouth daily however the medications pharmacy label indicates give twice daily.

Resident #9 is prescribed 5mg warfarin Tablet by mouth daily however the medication label indicates give 2.5 mg daily.

Resident #9 is prescribed 40 mg Furosumide tablet by mouth every other day however the medication pharmacy label indicated daily.

Resident #9 is prescribed is prescribed 20 meq potassium Chloride Er tablet by mouth every other day however the medication pharmacy label indicated give two tablets daily.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Above medication directions were immediately fixed upon discovery on 06/28/23 by facility administrator.

Medication technicians were re-educated at staff meeting on 07/12/23 regarding change of direction stickers and correct labeling of medications by head of medication training RN.

Head of medication training, developed and implemented plan on 07/01/23. Head of medication training will review weekly on Fridays to ensure that all labels correctly correspond to all orders.

Licensee's Proposed Overall Completion Date: *07/27/2023*

Not Implemented [redacted] - 11/29/2023)

185a - Implement Storage Procedures

24. 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

The homes policy for accountability for a scheduled and narcotic medication include a policy for staff count the scheduled medication at the end of the shift. However, resident #3 has 29 available in the home however the documentation of schedule and narcotic medication count sheet indicates 60 pills are available.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Medication technicians were immediately notified of error on 06/28/23 by facility administrator. Medication technician notified Diamond Drug to correct count on 06/28/23 and count was corrected by Diamond Drug. Medication was signed in twice by medication technician in error.

Staff were re-educated on narcotic counts at the end of each shift with oncoming shift at staff meeting on 07/12/23 by head of medication trainer.

Medication trainer Developed and implemented plan on 07/01/23 to verify narcotic count is correct every Friday by medication trainer RN

Licensee's Proposed Overall Completion Date: *07/27/2023*

Implemented [redacted] - 11/29/2023)

187b - Date/Time of Medication Admin.

25. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #3 is prescribed Lorazepam 0.5 mg tablet by mouth every 8 hours as needed for agitation. On 6/28/23 at 530 a.m. the staff person administering the medication did not initial the resident's June 2023 medication administration record (MAR).

Repeat Violation: 7/1/22, 5/24/22 et. al

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Staff member was notified by inspector of error and immediately documented medication administration on the MAR on 06/28/23.

All medication techs were re-educated at staff meeting on 07/12/23 regarding documentation at the time of medication administration by the Medication trainer RN.

Med trainer developed and implemented plan on 07/01/23 to review weekly on Fridays that all medications given were documented correctly. This will be completed by head med trainer RN.

Licensee's Proposed Overall Completion Date: *07/27/2023*

187b - Date/Time of Medication Admin. *(continued)*

Implemented [redacted] - 11/29/2023)

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

Facility Information

Name: *CRYSTAL WATERS* **License #:** *42765* **License Expiration:** *09/18/2023*

Address: *4639 ROUTE 119,HWY NORTH, HOME, PA 15747*

County: *INDIANA* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *CRYSTAL WATERS, INC.*

Address: *4639 ROUTE 119,HWY NORTH, HOME, PA, 15747*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/07/1998* **Issued By:** *L&I*

Type: *I-1* **Date:** *12/21/2010* **Issued By:** *Rayne Tmp.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *55* **Waking Staff:** *41*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *10/16/2023*

Inspection Dates and Department Representative

10/04/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *48*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *48*

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

Have Mobility Need: *7* **Have Physical Disability:** *1*

Inspections / Reviews

10/04/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/27/2023*

10/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/03/2023*

11/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/01/2023*

01/31/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Staff member A indicated that approximately 4 weeks ago [redacted] suspected staff member B had abused resident #1. Staff member A indicated [redacted] had witnessed staff member B being in a hurry while assisting resident #1 with [redacted] shower, bending resident #1's foot, causing the resident cry. However, the home failed to report this to protective services.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

Immediate: On 10/05/2023 Administrator, [redacted], discussed this event with the resident (1) who denied that [redacted] foot was bent or hurt during the shower. On 10/05/2023 Administrator, [redacted], also discussed with the staff member(B) who is accused of abuse, who also denied the allegation.
On 10/05/2023 written incident report was made and submitted by [redacted], administrator to departments personal care home regional office.

Incident was investigated by state inspector on day of inspection on 10/04/2023.

Corrective:
All staff members were re-educated on elder abuse and timely reporting at staff meeting on 10/19/2023 by [redacted] RN. All Staff also received education on elder abuse and reporting by watching online education module from Pennsylvania department of aging learning management system titled: "Elder abuse awareness training" on 10/19/2023.

Preventative:
Beginning on 11/1/2023 Administrator, [redacted], will ensure that all reports of abuse are reported within 24 hours to the departments personal care home regional office. Staff will be educated annually and during orientation on mandated abuse reporting and elder abuse by [redacted] RN.

Licensee's Proposed Overall Completion Date: *10/27/2023*

Not Implemented [redacted] 01/31/2024)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Staff member A indicated that approximately 4 weeks ago [redacted] suspected staff member B had abused resident #1. Staff member A indicated [redacted] had witnessed staff member B being in a hurry while assisting resident #1 with [redacted] shower, bending resident #1's foot, causing the resident cry. However, the home failed to report this to the department.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

Immediate: On 10/05/2023 Administrator, [redacted], discussed this event with the resident (1) who denied that

16c - Written Incident Report (continued)

[redacted] foot was bent or hurt during the shower. On 10/05/2023 Administrator, [redacted], also discussed with the staff member(B) who is accused of abuse, who also denied the allegation.
On 10/05/2023 written incident report was made and submitted by [redacted], administrator to departments personal care home regional office.
Incident was investigated by state inspector on day of inspection on 10/04/2023.
Corrective:
All staff members were re-educated on elder abuse and timely reporting at staff meeting on 10/19/2023 by [redacted] RN. All Staff also received education on elder abuse and reporting by watching online education module from Pennsylvania department of aging learning management system titled: "Elder abuse awareness training" on 10/19/2023.

Preventative:
Beginning on 11/01/2023 Administrator, [redacted], will ensure that all reports of abuse are reported within 24 hours to the departments personal care home regional office. Staff will be educated annually and during orientation on mandated abuse reporting and elder abuse by [redacted] RN.

Licensee's Proposed Overall Completion Date: 10/27/2023

Implemented ([redacted] 01/31/2024)

92 - Windows

3. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

The right window of the double window located in resident room #16's private bathroom had no screen in it. The window was operational.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

Immediate:
Screen was replaced in residents bathroom by head of maintenance, [redacted] upon discovery on 10/04/23.

Corrective:
Staff re-educated at staff meeting on 10/19/2023 held by [redacted] RN to notify administrator immediately if any screens are found to be removed or damaged. Educated that each window must have a screen.

Preventative:
Beginning on 11/01/2023 [redacted], head of maintenance, to complete monthly checks to ensure all screens are in place the first Friday of each month.

Licensee's Proposed Overall Completion Date: 10/27/2023

Not Implemented [redacted] - 01/31/2024)

101j7 - Lighting/Operable Lamp

4. Requirements

101j7 - Lighting/Operable Lamp *(continued)*

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

Resident #2 had no source of bedside light. The nearest source of light was located approximately 10 feet away from the head of the residence bed.

Resident #3 had no source of bed sidelight. The nearest source of light was located approximately 8 feet from the head of [redacted] bed.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

Immediate:
Resident number three did have a working touch lamp on [redacted] bedside table which is less than 6 inches from [redacted] head of bed at the time of inspection this was reviewed by [redacted] Administrator on 10/04/2023. See attached picture.

Resident number two's lamp was relocated to the head of [redacted] bed, and resident was re-educated that lamp must be kept at the head of [redacted] bedside by [redacted], administrator on 10/04/2023.

Corrective:
Staff was re-educated on keeping operable lamp that can be turned on at bedside for each resident at staff meeting on 10/19/23 held by [redacted], RN.

Preventative:
Beginning on 11/01/2023 Head of maintenance, [redacted], will check resident rooms monthly on the first Friday of every month to verify that bedside lamp is in place and operable.

Licensee's Proposed Overall Completion Date: *10/27/2023*

Not Implemented [redacted] - 01/31/2024)

127a - Portable Space Heaters

5. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

There was a black space heater approximately 16 x 16 inches in size on the bathroom floor of resident #4 room.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

Space heater was immediately removed upon discovery on 10/04/2023 by [redacted], RN (Medication trainer).

Corrective:
Staff re-educated at staff meeting on 10/19/2023 by [redacted] RN, that space heaters are not permitted in the building and that if one is found, it should be immediately reported to the administrator [redacted]) for proper removal.

127a - Portable Space Heaters (continued)

Resident was also re-educated that portable space heaters are against the home rules and are prohibited on 10/04/2023 by [redacted] RN.

Preventative:
Beginning on 11/01/2023 Administrator, [redacted], will complete weekly room checks every Friday to ensure that no space heaters are present.

Licensee's Proposed Overall Completion Date: *10/27/2023*

Not Implemented [redacted] - 01/31/2024)

184a - Resident's Meds Labeled

6. 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 #5 is prescribed Novolog INJ flex pen inject units subcutaneously before meals and at bedtime if blood sugar is 225 - 300 = 1, 301 - 375 = 2, 376 - 450 = 3, greater than 450 = 4, may be added to base dose of insulin if reading is high pre-meal or in lieu of base dose if meal is skipped and blood glucose is high. However, the NovoLog flex pen's label did not include the medication's sliding scale dosage instructions.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

Immediate:
Residents medication was properly labeled with correct label in medication storage container upon discovery on 10/04/2023 by medication technician [redacted].

Corrective:
Medication Technicians were re-educated on keeping prescription medications in original containers or having correct label on medication storage container. Education was taught by medication trainer [redacted], RN on 10/19/2023.

Preventative:
on 10/15/2023 [redacted] RN and head medication technicians [redacted] and [redacted] developed plan to ensure that all medications are labeled correctly as below:

The following Plan was implemented on 10/15/2023:
1. New orders will be reviewed by head medication technicians: [redacted]
2. Head medication technicians will then fax new orders to [redacted] Pharmacy to profile medication.
3. Head medication technicians will review pharmacy label/ order/ and EMAR to ensure that medication is

184a - Resident's Meds Labeled (continued)

correctly labeled and placed on EMAR.
4. All new orders will be placed in "NEW ORDER BINDER" for [redacted] RN (medication trainer) to be reviewed weekly on Friday to ensure labels and EMAR correctly correspond to the medication order.

Any medications that are discontinued will be removed from medication cart at time of order.

This was reviewed with all medication technicians on 10/19/2023 by [redacted] RN, head of medication training.

Licensee's Proposed Overall Completion Date: *10/27/2023*

Not Implemented [redacted] - 01/31/2024)

[redacted]

WITHDRAW

wed by Melissa Vaughn RN Head

2/7/24

very by Tina

[redacted]

[redacted]

Preventative:

[redacted]

WITHDRAWN

[redacted] 2/7/24