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

January 11, 2024

[redacted], ADMINISTRATOR
SERENITY CARE KINGSTON LLC
[redacted]

RE: SERENITY CARE KINGSTON
700 THIRD AVENUE
KINGSTON, PA, 18704
LICENSE/COC#: 23052

Dear [redacted],

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

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SERENITY CARE KINGSTON* **License #**: *23052* **License Expiration**: *03/28/2024*

Address: *700 THIRD AVENUE, KINGSTON, PA 18704*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *SERENITY CARE KINGSTON LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *75* **Waking Staff**: *56*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *11/07/2023*

Inspection Dates and Department Representative

11/07/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *122* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *rear, East* **Capacity**: *20* **Residents Served**: *17*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *9* **Are 60 Years of Age or Older**: *56*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

11/07/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/10/2023*

12/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/28/2023*

Inspections / Reviews *(continued)*

01/02/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/11/2024*

01/11/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

As noted in the Witness Statement provided by the home regarding the incident of 10-23-23, Direct Care Employee A pushed Resident #1 in the chest into his/her room . The physical struggle that ensued while Direct Care Employee A held Resident #1's door while Resident #1 attempted to get out of his/her room resulted in the resident sustaining a skin tear and bruising on the residents right arm. During the physical struggle with the door Direct Care Employee A was also yelling at Resident #1 to "Shut up! People are trying to sleep!"

Repeat Violation: 3/15/23

Plan of Correction ***Accept ([redacted] - 01/02/2024)***

This regulation was violated due to abuse occurring in the home. To fix this problem, employee involved in this incident was immediately removed from the facility at the time of the abuse occurred and terminated immediately on 10/23/23 by Administrator Justine Sweeting. As a community, we have zero tolerance for any violence or abuse in the workplace.
All contacts made to family, PCP, DHS, AAA on 10/23/23.
Administrator [redacted] is responsible for holding in-services yearly on abuse and providing in-services when abuse occurs to eliminate these incidents from occurring in the home. (see attached in-services sheets that include the dates of multiple in-services held after the incident occurred)
Administrator [redacted] is responsible for fixing the problem and to monitor ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/21/2023*

Implemented [redacted] - 01/11/2024)

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:
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct Care Employee A, date of hire [redacted], did not complete the first day of training components for smoke detectors/fire alarms and telephone use/ notification to emergency services until 8-6-23.

Plan of Correction ***Accept ([redacted] - 01/02/2024)***

This violation occurred due to employee not receiving fire safety training on her first day of orientation on 8/5/23. Employee received training on 2nd day of work.
This is the responsibility of the Administrator [redacted] and Business office manager [redacted] to be

65a FS Orientation 1st Day (continued)

sure we maintain compliance with fire safety orientation on first day of work. To fix this problem, a new signature form was created with a simple layout of what is to be completed in the first 40 hours of work during orientation. Administrator [redacted] and Business Office Manager [redacted] will be sure that all newly hired employees receive their fire safety training on first day of work and started an employee chart audit on 11/15/23 to eliminate the chances of this violation happening again. The employee file was marked audited and filed away due to no longer being employed. The administrator [redacted] is responsible for maintaining ongoing compliance with this regulation.

Licensee's Proposed Overall Completion Date: *01/08/2024*

Implemented ([redacted] - 01/11/2024)

202 - Prohibitions

3. Requirements

2600.
202. The following procedures are prohibited:
1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).

Description of Violation

On the night on [redacted] Employee A pushed Resident # 1 into His/her bedroom by the chest and pulled the door shut. Employee A then proceeded to hold the door shut forcibly preventing the resident from leaving the room, despite their efforts to exit on the other side of the door.

This action represent seclusion and is a prohibited act under regulation.

Plan of Correction ***Accept ([redacted] 01/02/2024)***

This regulation was violated due to abuse and seclusion occurring in the home. To fix this problem, employee involved in this incident was immediately removed from the facility at the time of the abuse occurred and terminated immediately on 10/23/23 by Administrator [redacted]. As a community, we have zero tolerance for any violence or abuse in the workplace.

All contacts made to family, PCP, DHS, AAA on 10/23/23.

Administrator [redacted] is responsible for holding in services yearly on abuse and providing in services when abuse occurs to eliminate these incidents from occurring in the home. (see attached in services sheets) Administrator [redacted] is responsible for fixing the problem and to monitor ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/21/2023*

Implemented [redacted] - 01/11/2024)

224a - Preadmission Screen Form

4. Requirements

224a Preadmission Screen Form *(continued)*

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident # 2 has a Pre-Adm Screen that was completed on [redacted]. The document did not indicate the home was able to meet her needs in the Personal Care Section of the Home.

Plan of Correction ***Accept ([redacted] - 01/02/2024)***

This violation occurred due to prescreen not being completed in full. This is the responsibility of the Administrator [redacted] and the Resident Care Director [redacted]. To fix this problem. Administrator reviewed prescreen determining that personal care home is able to meet the needs of the resident in our secured memory unit by marking audited with the date of 11/7/23.
To eliminate this violation from happening again, audits were started on 12/6/2023 of all resident charts, Administrator [redacted] and Resident Care Director are responsible for maintaining ongoing compliance with this regulation.

Licensee's Proposed Overall Completion Date: *01/10/2024*

Implemented ([redacted] - 01/11/2024)

234a Admission Support Plan

5. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident # 3 was admitted to the Home's Secure Dementia Care Unit on [redacted] The assessment portion of the Resident Assessment and Support Plan was completed on [redacted]. The Support Plan portion was not completed.

Repeat Violation: 5/25/23, 3/15/23

Plan of Correction ***Accept ([redacted] - 01/02/2024)***

This regulation was violated due to support plan not being completed with residents' admission to a secured unit. The Resident Care Director is responsible for completing RASP for all residents who enter the community in a

234a - Admission Support Plan (continued)

timely manner. To maintain in compliance with this regulation, the administrator [redacted] *is responsible for overseeing Resident Care Director* [redacted] *and to review care plan for errors after it is completed. To fix this problem, Resident Care Director updated care plan and marked audited in areas where there were errors. Administrator* [redacted] *and Resident Care Director* [redacted] *are responsible for maintaining ongoing compliance with this regulation. To eliminate the chances of this violation happening again, Audit of all resident charts were started on 12/6/2023 with a proposed completion day of 1/10/24.*

Licensee's Proposed Overall Completion Date: *01/10/2024*

Implemented [redacted] ***- 01/11/2024)***