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

April 18, 2024

[redacted], PRESIDENT
MAPLE VALLEY PERSONAL CARE HOME INC
2212 ANTHONY RUN ROAD
INDIANA, PA, 15701

RE: MAPLE VALLEY PERSONAL CARE HOME
2212 ANTHONY RUN ROAD
INDIANA, PA, 15701
LICENSE/COC#: 42769

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/12/2023 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: *MAPLE VALLEY PERSONAL CARE HOME* **License #**: *42769* **License Expiration**: *03/08/2024*

Address: *2212 ANTHONY RUN ROAD, INDIANA, PA 15701*

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

Administrator

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

Legal Entity

Name: *MAPLE VALLEY PERSONAL CARE HOME INC*

Address: *2212 ANTHONY RUN ROAD, INDIANA, PA, 15701*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/01/2008* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *47* **Waking Staff**: *35*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/12/2023*

Inspection Dates and Department Representative

12/12/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *36*

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**: *36*

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

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

12/12/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/06/2024*

01/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/11/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/19/2024*

Inspections / Reviews *(continued)*

03/04/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/11/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/18/2024*

04/18/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/11/2024*

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

On 12/12/23, the most current license inspection summary was dated 9/28/21.

Plan of Correction ***Accept (- 01/12/2024)***

On 12/12/2023 assistant to the administrator was notified that we need a prior inspection summary, and immediately looked into retaining a copy to post in a conspicuous location.

The assistant to the administrator on 12/13/2023 posted the prior inspection summary in a conspicuous location, which is on a bulletin board in the activity room.

The assistant to the administrator will check every three months starting 01/13/2024 that the most recent inspection summary is located in a conspicuous place.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented (- 04/18/2024)

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

Ancillary staff person A, hired , did not have a Pennsylvania Criminal Background Check competed until 1 .

Plan of Correction ***Accept - 01/12/2024)***

The administrator on the date of inspection 12/12/2023, immediately obtained a criminal history for Ancillary staff person A and gave to the inspector on site.

The director of operations checked all the employee files on 12/13/2023 to ensure that all the staff have a criminal history, which is located in each employee file.

The director of operations will check every three months starting 01/13/2024 that all employees have a criminal history in their employee file.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented - 04/18/2024)

54a - Direct Care Staff

3. Requirements

54a Direct Care Staff *(continued)*

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 B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 03/04/2024)***

Administrator called DHS to discuss the violation regarding direct care staff person B on 01/05/2024.

Administrator assisted direct care staff person B with enrolling in a GED program on 01/10/2024. Direct staff person B will start GED classes on 01/17/2024.

Administrator and director of operations upon hiring staff will discuss and review new employee's files more closely to determine they have the proper qualifications which the direct care staff need. Director of operations will review employee files every month starting 01/11/2024.

-Staff person B will not do direct care services with the residents till they complete their GED.

Employee file review shall include ensuring that each direct care staff person has documentation of a High School diploma, GED or active registry status on the PA nurse aide registry in their record. 3/4/24

Proposed Overall Completion Date: 02/23/2024

Licensee's Proposed Overall Completion Date: *02/23/2024*

Implemented (- 04/18/2024)

64c Annual Training

4. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person C, the home's administrator, completed only 7 hours of Department-approved training in training year 1/1/2022 to 12/31/22.

Plan of Correction ***Directed - 03/04/2024)***

Administrator received a email response from Jason Williams we had a licensed second administrator that had completed the proper amount of training hours.

64c - Annual Training (continued)

Proposed Overall Completion Date: 02/23/2024

DIRECTED PLAN
By 3/15/24: The home shall employ an administrator who meets the qualifications as required by 2600.53a and has completed the required orientation and training as required by 2600.64a. Documentation of these qualifications and training shall be kept.

Directed Completion Date: *02/23/2024*

Implemented [redacted] - 04/18/2024)

65f - Training Topics

5. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Direct care staff person D did not receive training in the following during training year 1/1/22 to 12/31/22:

** Medication Self-administration*

** Instruction on meeting the needs of residents described in medical evaluation, assessment, and support plan*

** Personal care service of the residents*

** Safe Management*

Plan of Correction ***Accept ([redacted] - 03/04/2024)***

Administrator looked into direct care staff person D trainings on 12/13/2023 for the training year 01/01/2022 to 12/31/2022, this was a simple documentation error. Staff person D was in fact at the stated trainings, she simply did not sign the roster that day. Documentation is attached, verifying that staff person D did complete the above trainings, but simply forgot to sign the roaster.

Administrator immediately on 12/13/2023 came up with a resolution that the assistant to the administrator will review training rosters on the day of the scheduled training to ensure all in attendance sign the roster.

Assistant to the administrator will start on 01/01/2024 that all employees in attendance at trainings will sign the roster for the scheduled training, and each staff member will have a training sheet which assistant to the administrator will review every 3 months starting 02/07/2024, to determine the staff completes all the annual trainings.

Licensee's Proposed Overall Completion Date: *02/23/2024*

65f - Training Topics *(continued)*

Implemented [redacted] - 04/18/2024)

65g - Annual Training Content

6. 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:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person B did not receive training in Emergency Preparedness during training year 1/1/22 to 12/31/22.

Plan of Correction ***Accept [redacted] - 01/17/2024)***

Administrator immediately checked on 12/13/2023 staff person B completed emergency preparedness training in July 2023.

Assistant to the administrator completed a review of all employee trainings on 12/31/2023 to ensure staff have completed emergency preparedness training.

Assistant to the administrator will review training logs monthly starting 01/01/2024.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented [redacted] - 04/18/2024)

101j7 - Lighting/Operable Lamp

7. 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

Resident #1, in bedroom #24, did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 01/17/2024)***

The administrator immediately on 12/12/2023, day of inspection, moved a small lamp that was in residents #1 room, to her bedside table. Administrator checked to ensure that the lamp worked properly and could be turned on and off.

101j7 - Lighting/Operable Lamp (continued)

The director of operations went to all the resident's rooms on 12/13/2023 to check each resident's room, had a functioning light beside their bedside, that can be turned on and off.

The director of operations will check monthly starting 01/13/2024 that each residents has a functioning source of light beside their bed.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented [redacted] - 04/18/2024)

103g - Storing Food

8. Requirements

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

Description of Violation

The bag of breaded chicken strips in the upright freezer in the kitchen was opened and unsealed.

Plan of Correction ***Accept ([redacted] - 01/17/2024)***

The kitchen manager immediately on 12/12/2023 on day of inspection applied a clasp to the bag of breaded chicken strips to ensure that the bag was sealed properly.

The kitchen manager immediately on 12/13/2023 went through the freezers to ensure that the food was properly stored in closed or sealed containers.

The kitchen manager will check weekly starting 01/13/2024, that food in the freezers is properly stored in closed or sealed containers.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented ([redacted] - 04/18/2024)

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

On 12/12/23, at approximately 11:20 am., the emergency exit door at the end of Mountain Maple hallway had a "stop" sign posted on the emergency exit door, giving the impression that the door is not to be used; therefore, blocking this egress from the home.

Plan of Correction ***Accept ([redacted] - 01/17/2024)***

The administrator immediately on 12/12/2023 toke down the stop sign on the door located at the emergency exit door in mountain wing.

121a - Unobstructed Egress (continued)

The administrator on 12/13/2023 went through to check all the emergency exit doors to ensure that there was nothing obstructing the emergency exit doors.

The administrator starting 01/13/2024 will check all the exit doors weekly to ensure that there is nothing obstructing the exit doors.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented (- 04/18/2024)

183e - Storing Medications

10. 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

On 12/12/23, resident #3's medication, were opened and not dated to the opening date. According to the manufacturer's instructions dispose of six months after opening.

Plan of Correction ***Accept (- 03/04/2024)***

The director of nursing immediately on 12/12/2023 put a date open sticker on resident #3 with the date it was opened.

The director of nursing checked all medications that have expirations dates and will audit them on 12/13/2023 to ensure that all the eyedrops, insulins, vials, nose sprays, etc had a date open sticker that were properly dated and were not expired.

The director of nursing will audit all medications in the audit system, that have an expiration date after you open them starting weekly on, 12/20/2023 to ensure all medications with an expiration date are properly audited and dated.

Licensee's Proposed Overall Completion Date: *02/23/2024*

Implemented - 04/18/2024)

184a - Resident's Meds Labeled

11. Requirements

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

Description of Violation

The medication, , is in the medication cart but not listed on the resident #3's December 2023 medication administration record (MAR).

The pharmacy label for resident #3's does not include the strength of the medication.

184a Resident's Meds Labeled (continued)

Resident #4 is prescribed [redacted], 1 tab every 6 hours as needed. The pharmacy label indicates 1 tab every 8 hours as needed.

Plan of Correction ***Accept [redacted] - 01/17/2024)***

The director of nursing on 12/12/2023 called [redacted] Pharmacy to reactivate [redacted] for resident #3 in Emar System.

The director of nursing on 12/13/2023 checked medications in Emar System to ensure that all the medications were entered in the Emar system properly.

The director of nursing will check weekly starting 01/13/2024 that medications are not expiring out in the Emar system and if so, contact [redacted] Pharmacy to reactivate medication so it does not expire in the Emar system.

The director of nursing immediately called [redacted] Pharmacy on 12/12/2023 to inform them that there is no dosage listed for resident #3 [redacted] on the Prada pack, and we need there to be a dosage listed on the [redacted] pack for #3 [redacted]

The director of nursing followed up with [redacted] on 12/13/2023, to ensure that they will put the dosage on the Acidophilus for resident #3 [redacted] Pharmacy informed the director of nursing that the dosage will be listed on future Prada packs.

The director of nursing will go through the [redacted] packs every month starting 01/13/2023 to ensure that the dosage is listed on the Prada packs.

The director of nursing immediately on [redacted] applied a change of date sticker on the bottle of [redacted] [redacted] for resident #4.

The director of nursing went through to check residents' medications on 12/13/2023 to ensure that the medications matched the directions in the Emar system.

The director of nursing will check monthly starting 01/13/2023 to ensure that the directions in the Emar system match the medication label.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented [redacted] - 04/18/2024)

185a - Implement Storage Procedures

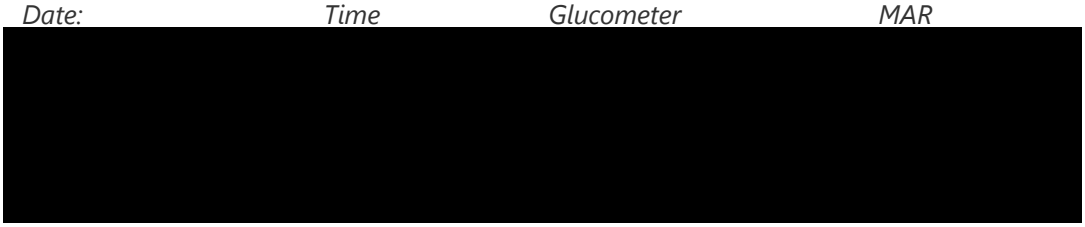
12. Requirements

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 #5 is prescribed blood glucose checks 5 times a day. However, the resident's glucometer indicates blood glucose levels that are not indicated on the resident's December 2023 MAR.

Date: Time Glucometer MAR



Plan of Correction ***Accept [redacted] - 01/17/2024)***

The director of nursing immediately on 12/12/2023 verbally instructed the staff that we need an order to check blood sugars outside of the prescribed times for resident #5.

The director of nursing immediately on 12/13/2023 obtained a PRN order to check resident #5 blood sugar 3 other times as needed for DM outside of the prescribed 5 times we check the residents blood sugar.

The director of nursing will check monthly starting 01/13/2024, to ensure that the staff check residents #5 blood sugar outside of the 5 regular times resident #5 gets their blood sugar checked, that they put them under the residents PRN order.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented [redacted] - 04/18/2024)

190b - Insulin Injections

13. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 12/5/23, at 12:00 pm., staff person E who has not completed the Department-approved diabetes patient education program within the past 12 months, administered insulin to resident #5.

Plan of Correction ***Accept ([redacted] - 01/17/2024)***

The administrator had an approved diabetes patient education program scheduled for 12/15/2023, which staff person E attended. Which staff person E received her department approved diabetes patient education training.

190b Insulin Injections (continued)

The administrator immediately on 12/13/2023 went through and checked staff's files to ensure that the staff were up to date on diabetes patient education program.

The administrator starting 01/13/2024 will check monthly that staff are up to date on the diabetes patient education program.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented [redacted] - 04/18/2024)