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

March 15, 2024

[redacted], ADMINISTRATOR
135 VERMONT DRIVE OPERATING COMPANY LLC
[redacted]

RE: SERENITY GARDENS AT MOUNT CARMEL
135 VERMONT DRIVE
KULPMONT, PA, 17834
LICENSE/COC#: 23101

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/08/2024, 02/14/2024 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]
Acting Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SERENITY GARDENS AT MOUNT CARMEL* **License #**: *23101* **License Expiration**: *11/21/2024*

Address: *135 VERMONT DRIVE, KULPMONT, PA 17834*

County: *NORTHUMBERLAND* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *135 VERMONT DRIVE OPERATING COMPANY LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/20/2001* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/14/2024*

Inspection Dates and Department Representative

02/08/2024 - On-Site: [redacted]

02/14/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *49*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Ivy* **Capacity**: *22* **Residents Served**: *17*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *49*

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

Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

02/08/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/07/2024*

03/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/14/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/11/2024*

Inspections / Reviews *(continued)*

03/15/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/14/2024*

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

65d Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [redacted] did not complete and pass the Department-approved direct care training course and pass the competency test upon hire and before working with residents unsupervised.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

65.d.
Direct care staff persons hired after [redacted], may not provide unsupervised ADL services until completion of the following:
2.
Successful completion and passing the Department-approved direct care training course and passing of the competency test.
On 3/1/24 Office Manager conducted an initial audit of all current direct care staff members to ensure DHS training has been completed for all staff working unsupervised. An audit checklist will be completed by Office Manager for each new employee within first 40 hours of employment to ensure completion of DHS training for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/07/2024*

Implemented ([redacted] - 03/15/2024)

101j7 Lighting/Operable Lamp

2. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

Description of Violation

Residents in rooms 302 and 307 did not have an operable lamp or other source of lighting that could be turned on at bedside.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

101.j.
Each resident shall have the following in the bedroom:

On February 26, 2024 Administrator and Director of Housekeeping completed an audit of all rooms on the secure 300 unit to ensure each room was equipped with a working light source at their bedside. All bedside tables were moved 3 inches or more closer to bedside to ensure light could be reached while residents were lying in down. Director of Housekeeping will complete weekly room audits until 100% compliance is reached for a period of 4 consecutive weeks. Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/25/2024*

Implemented ([redacted] - 03/15/2024)

102f - Towel/Washcloth/Soap

3. Requirements

2600.
102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

Room 302 is a shared room. The bathroom had 1 bar of soap located on the sink. The bars of soap was not labeled or in a labeled container.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

2600.
102.f. An individual towel, washcloth and soap shall be provided for each resident.

On 2/14/24 The soap was disposed of while surveyor was on site. Staff will be educated on proper labeling and storage of poisonous/hazardous materials on March 12,2024. Beginning 3/1/24 housekeeping supervisor or designated person will conduct room audits on all room in the secure unit weekly until 100% compliance is reached for 4 consecutive weeks. Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented ([redacted] - 03/15/2024)

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

Located in the kitchens can storage area is a can rack. On that rack, were 2 cans that had dents on them, a can of mushrooms and apricots.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

103.i. Outdated or spoiled food or dented cans may not be used.

On 2/14/24 the 2 cans in question were removed while surveyor was on site. Director of Dietary completed an audit of all cans stored in the facility while surveyor was on site. Beginning 3/1/24 Dietary Director will complete weekly can audits until 100% compliance is reached for 8 consecutive weeks. All dietary staff will be educated of proper storage of can goods and the procedure for removing damaged cans and placing them in the designated area until credit is received from the vendor. Once credit is received, cans will be destroyed. Dietary Director will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/25/2024*

Implemented ([redacted] - 03/15/2024)

121a - Unobstructed Egress

5. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

121a - Unobstructed Egress *(continued)*

Description of Violation

Ivy Lane has a courtyard with a fence that has a code. The code opens the fence. After a recent snowstorm, the snow was not removed from behind the gate, which block immediate egress in the event of an emergency.

Plan of Correction ***Accept (- 03/08/2024)***

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

On 2/14/24 snow was removed from the outside gate while surveyor was on site. Director of Maintenance was educated on all egresses throughout the building and the importance of keeping them clear from snow. Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/07/2024*

Implemented - 03/15/2024)

183b - Meds and Syringes Locked

6. 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

On , spray was unlocked, unattended, and accessible in resident #1's room. During MedCart audit on , Staff A, left the med cart unattended numerous times to attend to residents or to get medications from other locations. During these times, medications were left unattended on top of the medication cart.

Plan of Correction ***Accept (- 03/08/2024)***

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.

Plan of correction
On 2/14/24 the was removed from resident 1's room. Beginning 3/4/24 Resident care coordinator or authorized designee will perform weekly room audit to ensure no medications are stored in a resident room until 100% compliance is reached for a period of 4 consecutive weeks.
Nursing staff will be re-educated on the medication administration process including but not limited to the proper storage of medications, watching residents take their medication, not leaving medication unattended and keeping med carts locked when not supervised. The training will be held on 3/12/24. DOW will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/01/2024*

Implemented (- 03/15/2024)

184a - Resident's Meds Labeled

7. Requirements

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

184a Resident's Meds Labeled *(continued)*

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident # 1's Medication Administration Record states that Resident #1 takes [redacted] once a day at bedtime and 1 tablet every 6 hours as needed for increased [redacted]. However, the medication pill pack states the Resident takes the medication every 6 hours as needed.
There was a tube of desitin in the medicine cart. The medication did not have a pharmacy label or a resident's name on it, indicating which resident the medication was for. Staff A indicated it belongs to resident #1.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

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.

Resident # 1's Medication Administration Record states that Resident #1 takes [redacted] once a day at bedtime and 1 tablet every 6 hours as needed for increased [redacted]. However, the medication pill pack states the Resident takes the medication every 6 hours as needed.
There was a tube of [redacted] in the medicine cart. The medication did not have a pharmacy label or a resident's name on it, indicating which resident the medication was for. Staff A indicated it belongs to resident #1.
On 3/1/24 DOW conducted an audit of the cart where resident ones medications are stored and compared medication labels with orders in PCC to ensure they match the prescribers orders. Beginning on March 1, DOW or assigned designee will complete monthly cart audits for ongoing compliance. An audit sheet has been created to include the comparison.
On 3/1/24 DOW conducted an audit of the treatment cart where medications are stored to ensure proper labeling. Beginning March 1 the DOW or assigned designee will complete an audit of all medication stored in the cart for proper labeling. An audit sheet has been created for ongoing compliance. Staff will be educated on proper storage of treatment medications at a staff meeting scheduled for March 12,2024. DOW will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Implemented ([redacted] - 03/15/2024)

185a - Implement Storage Procedures

8. 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 #1 has a order for [redacted], to be applied 2x a week. This medication was not available.
Resident #2 has a PRN order for [redacted] 3x a day for cough. This medication is not available.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

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.

On [redacted] DOW received a d/c order the the [redacted].
On [redacted] DOW received a d/c order for the [redacted].

185a - Implement Storage Procedures (continued)

On March 1, 2024 DOW conducted an audit of the carts where resident one and two's medications were stored and did a comparison of labels on medications and cards to ensure they match the prescribers orders and all medications listed on the MAR are on hand and available. The DOW has created a monthly audit sheet to ensure the availability of medications for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/07/2024*

Implemented [redacted] - 03/15/2024)

185b - Medication Procedures

9. Requirements

2600.
185.b. At a minimum, the procedures must include:
2. A process to investigate and account for missing medications and medication errors.

Description of Violation

The narcotic policy of the home indicates that MedTechs and LPNS are required to count controlled medications together at each change of shift; any errors or missing medication issues require immediate notification to the Administrator. During med cart audit, it was discovered the narcotic count of Resident #3's [redacted] was not accurate. Staff A indicated that a narcotic count was not completed at the beginning of the shift. Through further investigation, it was determined that resident #3 receives 2 doses per day. On [redacted], only 1 dose was documented on the control sheet, therefore the count was not accurate since then.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

185.b. At a minimum, the procedures must include:

2. A process to investigate and account for missing medications and medication errors.

Plan of correction:
All staff members working from 2-11 to 2-14 received a final written warning for violation of the company narcotic policy. Between 2-11 and 2-14 the Administrator or DOW observed the med counts at the change of shift to ensure ongoing compliance. At a staff meeting on 3-12 Staff will be re-educated on the company narcotic policy. Staff will sign off that they understand the policy and future violation could/will result in termination. DOW or administrator will complete weekly random spot audits to check count accuracy and proper documentation until 100% accuracy has been reached for 8 consecutive weeks. DOW will monitor for ongoing compliance.

185b Medication Procedures (continued)

Licensee's Proposed Overall Completion Date: *03/12/2024*

Implemented (- 03/15/2024)

187d - Follow Prescriber's Orders

10. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #4 is prescribed tablet one time a day in the morning. On , the dose was not administered. The medication was not administered as prescribed.

Plan of Correction ***Accept - 03/08/2024)***

187.d. The home shall follow the directions of the prescriber.

Plan of Correction
On 2/14/24 DOW completed a medication count of the prescribed Levothyroxine to ensure resident 4 received the dose as prescribed. Resident #4 did receive the prescribed dose. Resident #4 confirmed he has not missed any doses of the 6 am medication. Staff will be reeducated on proper documentation of administered medication at a staff meeting on 3/12/24. The DOW and/or designee will do weekly cart audits beginning on 03/04/24 x 4 weeks to ensure all residents receive medications as prescribed by the prescriber. DOW will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/01/2024*

Implemented (- 03/15/2024)

227c - Support Plan Revision

11. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #5's most recent Assessment and Support plan, dated , does not indicate resident is on hospice services. Date admitted to hospice is a significant change

Plan of Correction ***Accept (- 03/08/2024)***

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Plan of correction
On an addendum was added to resident #5 RASP to include hospice services.
On a blank addendum sheet was added to all; resident support plans.

227c Support Plan Revision (continued)

On 2/15/24 DOW re educated RCC and MCC on proper documentation of what is to be in the support plan and when updating is necessary,
RCC and MCC will perform an audit of all support plans to be completed by 3/31/24 to ensure proper documentation is completed within proper timeframe. DOW will review for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented (- 03/15/2024)

227d - Support Plan Medical/Dental

12. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

On [redacted] Resident #6 had a fall with an injury that resulted in a compound fracture of the wrist. An addendum was not completed to indicate what the home was doing to ensure the safety of the resident.

Plan of Correction ***Accept (- 03/08/2024)***

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

Plan of correction
On 2/15/24 a blank addendum sheet was added to all; resident support plans.
On 2/15/24 DOW re educated RCC and MCC on proper documentation of what is to be in the support plan and when updating is necessary,
RCC and MCC will perform an audit of all support plans to be completed by 3/31/24 to ensure proper documentation. DOW will review for compliance.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented - 03/15/2024)