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

May 16, 2024

[redacted], CEO
UMH PA CORP
50 WEST TIOGA STREET
TUNKHANNOCK, PA, 18657

RE: TUNKHANNOCK MANOR
50 WEST TIOGA STREET
TUNKHANNOCK, PA, 18657
LICENSE/COC#: 23655

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/05/2024 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *TUNKHANNOCK MANOR* **License #**: *23655* **License Expiration**: *12/08/2024*

Address: *50 WEST TIOGA STREET, TUNKHANNOCK, PA 18657*

County: *WYOMING* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *UMH PA CORP*

Address: *50 WEST TIOGA STREET, TUNKHANNOCK, PA, 18657*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/18/2023* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *32* **Waking Staff**: *24*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *03/05/2024*

Inspection Dates and Department Representative

03/05/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served**: *26*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *38* **Residents Served**: *26*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *26*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *6*

Have Physical Disability: *0*

Inspections / Reviews

03/05/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/29/2024*

04/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/12/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/05/2024*

Inspections / Reviews *(continued)*

04/05/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/12/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/12/2024*

05/16/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/12/2024*

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

20b8 Quarterly Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home did not provide resident #1 or the resident's designee an itemized account of financial transactions made on the resident's behalf for the last quarter of 2023.

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

Administrative Assistant was re-educated on 3/6/24 on the policy to provide quarterly, and itemized account of transactions made on resident's behalf. Resident #1 received an itemized account of their financial transactions on 3/6/24 for the last quarter which is filed with administration. That same day, Administrator conducted an audit of all residents with funds held in the building to ensure they received an itemized account of financial transactions made on the residents' behalf on a quarterly basis. This audit will continue quarterly.

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

Implemented [redacted] - 05/16/2024)

63a First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

The home did not have at least one staff person with FA/CPR training on the following dates and times:

[redacted]

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

Staff Development has been educated related to the need to have at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR in the home at all times. A FA/CPR training was held in this facility on 3-11-24. Nursing staff is now in compliance with at least one certified staff person on each shift. Certification cards will be printed and filed with the administrator. The Administrator and/or designee will continue to conduct audits of the staff that are FA/CPR trained to maintain continued compliance. These audits will take place annually in March to remain in compliance.

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

Implemented [redacted] - 05/16/2024)

65f Training Topics

3. Requirements

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

65f - Training Topics *(continued)*

6. Safe management techniques.

Description of Violation

Staff person A did not have training in the required training topic Safe Management Techniques for the 2023 training year.

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

Staff Development has been educated related to the need to have the required topic of Safe Management Techniques annually. Staff Member A was educated on the required training topic Safe Management Techniques. All direct care staff will be educated on the required training topic Safe Management Techniques by 4/12/2024. The Administrator will audit 100% of direct care employee education records to ensure they received the required training topic of Safe Management Techniques, this will be done by 4/12/2024 as well. Administrator will be responsible for ongoing compliance of Safe Management Techniques.

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

Implemented [redacted] - 05/16/2024)

65g - Annual Training Content

4. 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 A did not have training in the following required topics for the 2023 training year:
Resident rights.
Staff person B did not have training in the following required topics for the 2023 training year:
Resident rights; falls and accident prevention; emergency preparedness procedures
Staff person C did not have training in the following required topics for the 2023 training year:
Resident rights; falls and accident prevention
Staff persons A, B, and C also did not have the required fire safety training by a fire safety expert for 2023.

Plan of Correction ***Accept [redacted] - 04/05/2024)***

Staff Development has been educated related to the need to have the required topics of resident rights, falls and accident prevention and emergency preparedness procedures annually. Staff Member A was educated related to resident Rights. Staff member B was educated related to Resident Rights, Falls and Accident Prevention, and Emergency Preparedness procedures. Staff person C was educated related to Resident Rights and Falls and Accident Prevention. All staff and volunteers will be educated on the required training topic of Resident Rights, Falls and Accident Prevention, and Emergency Preparedness procedures by 4/12/2024. The Administrator will audit 100% of employee and volunteer education records to ensure they received the required training topics of Resident Rights,

65g Annual Training Content (continued)

Falls and Accident Prevention, and Emergency Preparedness procedures. This will be complete by 4/12/24. Administrator will be responsible for ongoing compliance.
The Administrator has been re educated related to the need for annual fire safety training completed by a fire safety expert. The facility has engaged [redacted], a fire safety expert, to conduct fire safety training. Staff persons A, B, and C will be included in these trainings. The Administrator will ensure the continuation of fire safety training by a fire safety expert.

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

Implemented [redacted] - 05/16/2024)

82c - Locking Poisonous Materials

5. 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

A can of PB Blast, an oil based spray lubricant, was found in the outdoor courtyard where it was accessible to residents who are assessed to be unsafe to use and avoid poisonous materials. Also, a bottle of alcohol based hand sanitizer was found in a cupboard in the dining area.

Plan of Correction ***Accept ([redacted] - 04/05/2024)***

Both items were immediately removed 3/5/24. All staff will be educated by 4/12/2024 on the regulation regarding 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. The Administrator and/or Designee will conduct a weekly audit, starting 3/6/24, to ensure poisonous materials are kept locked and inaccessible to residents. This audit will be reevaluated in three months. Administrator will be responsible for ongoing compliance.

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

Implemented [redacted] - 05/16/2024)

96a - First Aid Kit

6. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the 2nd floor kitchenette area did not contain bandages. The first aid kit in the home's kitchen did not contain scissors and gauze

Plan of Correction ***Accept [redacted] - 04/05/2024)***

All first aid kits were audited and replenished by the Administrator during the survey on 3/5/24. The Administrator was re educated related to the items required to be in the first aid kits on 3/7/24. All required supplies are in each first aid kit at this time. Monthly audits will be performed by administrator and/or designee to ensure the required items are in the first aid kits. Completed 3/5/24

96a - First Aid Kit *(continued)*

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

Implemented [redacted] - 05/16/2024)

121a - Unobstructed Egress

7. 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

The gate located in the courtyard that was locked with a coded key pad did not open when the code was entered into the keypad. The keypad was not functioning at the time of the initial walk-through.

Plan of Correction ***Accept ([redacted] - 04/05/2024)***

Northeast Protection Partners was called same day on 3/5/24 to inform of faulty outdoor keypad. They inspected it next day on 3/6/24 and replaced keypad. Outdoor gate is now fully functional. This coded keypad will be added to the Preventative Maintenance list for weekly inspection of function. Maintenance Technician will be responsible for compliance.
Completed 3/6/24

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

Implemented ([redacted] - 05/16/2024)

132a - Monthly Fire Drill

8. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home did not conduct a fire drill during the month of February 2024.

Plan of Correction ***Accept [redacted] 04/05/2024)***

The Administrator and Maintenance Supervisor were re-educated on Regulation 132.a on 3/7/24. The Maintenance Supervisor was trained to perform the required monthly fire drills as well as the overnight fire drills. Administrator to audit fire drill log monthly to maintain continued compliance. Maintenance Technician will be performing an unannounced fire drill by 4/5/24.

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

Implemented [redacted] - 05/16/2024)

132e - Fire Drill Sleeping Hours

9. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

132e - Fire Drill Sleeping Hours *(continued)*

Description of Violation

The home's most current overnight sleeping hour drill was conducted on 8/1/2023. The home was due to complete another overnight sleeping hour drill six months later on 2/1/24 but no fire drill was conducted in February 2024.

Plan of Correction ***Accept (- 04/05/2024)***

The Administrator and Maintenance Supervisor were re-educated on Regulation 132.e. on 3/7/24/ The Maintenance Supervisor was trained and perform the required sleeping hour fire drills every six months. Administrator to audit fire drill log monthly to maintain continued compliance. Maintenance technician will perform an unannounced overnight fire drill by 4/5/24.

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

Implemented (- 05/16/2024)

182b - Prescription Medication

10. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 3/2/24 from 11pm to 7am the home did not have a staff person in the home with current, documented medication administration training.

Plan of Correction ***Accept (- 04/05/2024)***

Staff member without documentation of med tech certification is being re-trained and this training documentation will be maintained on file at the Home. Staff member is currently in the process of finishing the online course. The Administrator was re-educated related to the need to maintain current records of medication administration training on 3/7/24. Monthly audits to be done by Administrator and/or designee to ensure re-certifications are complete and proof is retained to maintain continued compliance. Audits were complete 3/7/24 and will continue monthly.

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

Implemented - 05/16/2024)

227d - Support Plan Medical/Dental

11. 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

Resident #1 uses a bedside mobility device. The resident's Support Plan dated does not reflect any risks associated with the device, the resident's ability to use the device safely for the intended purpose, identification of the

227d Support Plan Medical/Dental (continued)

specific device to be used and if a cover is required to meet FDA guidelines.
Resident #2 uses a bedside mobility device. The resident's Support Plan dated [redacted] does not reflect any risks associated with the device, the resident's ability to use the device safely for the intended purpose, identification of the specific device to be used and if a cover is required to meet FDA guidelines.
Repeated violation 11/22/22.

Plan of Correction ***Accept [redacted] - 04/05/2024)***

Resident #1 and #2's support plans were updated on [redacted] to reflect proper verbiage for utilizing a bedside mobility device. Nursing supervisor and Administrator was re educated on 3/7/24 on the need to have the support plan for residents utilizing a bedside mobility device reflect any risks associated for the device, the residents' ability to use the device safely for the intended purpose, identification of the specific device to be used and if a cover is required to meet FDA guidelines. After education, all residents with bedside mobility devices have had their RASP audited by administrator to ensure the RASPs are in compliance. The Administrator and/or designee will audit RASPs on residents with new beside mobility device to maintain continued compliance on this regulation. Audits of current residents support plans were complete on 3/28/24.

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

Implemented [redacted] - 05/16/2024)

231b - Medical Evaluation

12. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the home's secure dementia unit on [redacted]. The medical evaluation dated [redacted] does not indicate the need for secure dementia care.

Plan of Correction ***Accept [redacted] - 04/05/2024)***

Resident #3's DME was updated and signed by the physician on [redacted] to reflect the need for secure dementia unit. All memory care residents DME's were audited by the administrator on [redacted] to ensure continued compliance with regulation 231.b. All residents admitted to the home's secure dementia unit will have their medical evaluations reviewed to ensure it indicates the need for secure dementia care. Administrator will be responsible for this compliance.

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

Implemented [redacted] - 05/16/2024)

231c - Preadmission Screening

13. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

231c Preadmission Screening *(continued)*

Description of Violation

Resident #3 was admitted to the home's secure dementia unit on [redacted]. The home did not complete a cognitive preadmission screening for this resident.

Plan of Correction ***Accept ([redacted] - 04/05/2024)***

Resident #3's preadmission screening was completed to compliance on [redacted] The Administrator was re educated related to the need to complete a cognitive preadmission screening 72 hours prior to admission to a secure dementia care unit. All residents who converted to memory care have had their charts audited by the Administrator 3/11/24 and all preadmission screenings present. The Administrator or designee will perform an audit on all future memory care residents to ensure there is a completed cognitive preadmission screening 72 hours prior to admission to a secure dementia care unit.

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

Implemented [redacted] - 05/16/2024)

233c - Key-Locking Devices

14. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The home's courtyard gate is locked with a key pad installed next to the gate. The key pad did not have a code posted on or near it to indicated how to unlock the gate.

Plan of Correction ***Accept ([redacted] - 04/05/2024)***

The required code was installed inconspicuously next to the keypad on same day.
Completed 3/5/24. The Maintenance Supervisor will conduct monthly audits starting 4/5/24 to maintain the codes for the gates are conspicuously posted. The Administrator will audit this process for 3 months to maintain compliance with regulation 233.c.

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

Implemented [redacted] - 05/16/2024)