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

August 7, 2024

[redacted], OWNER
EVADNEY SCOGGINS
[redacted]

RE: SCOGGINS PERSONAL CARE
BOARDING HOME
1245 WEST TIOGA STREET
PHILADELPHIA, PA, 19140
LICENSE/COC#: 14015

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/14/2024 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SCOGGINS PERSONAL CARE BOARDING HOME* **License #**: *14015* **License Expiration**: *10/11/2024*

Address: *1245 WEST TIOGA STREET, PHILADELPHIA, PA 19140*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *EVADNEY SCOGGINS*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *08/06/2012* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/14/2024*

Inspection Dates and Department Representative

03/14/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *14*

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability**: *4*

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

Inspections / Reviews

03/14/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/01/2024*

04/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/08/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/15/2024*

Inspections / Reviews *(continued)*

05/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/08/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/07/2024*

08/07/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/08/2024*

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

26a - Quality Management Plan

1. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not have a quality management plan on 3/14/2024.

Plan of Correction ***Accept ([redacted] - 04/12/2024)***

On 3/14/2024 The Quality management plan was not in the policy folder. The policy is clearly listed in the table of content log. Attached is a copy of the plan. Going forward the administrator and the assistant administrator will check the policy manual at least each quarter to ensure that every item is in place. If anything is missing it will be corrected immediately. The administrator and the assistant admin will be responsible for continued compliance. The new copy was inserted into the folder on3/17/2024. See attached.

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented ([redacted] - 06/12/2024)

64c - Annual Training

2. 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 [redacted] who is the home's administrator, did not provide documentation of any annual training for training year 7/1/2022-6/30/23.

Plan of Correction ***Accept ([redacted] - 05/06/2024)***

The administrator and designee are currently enrolled in the Long-Term Care Learning Center. They are both enrolled in 12.5 credits under the Long-Term Care Learning Center. As of 05/03/24, most of the 12.5 credits have been completed, and certificates are available upon request. In addition to this, they are both taking 5 online credits and six additional in-person credits, both under PEPP Unlimited. The online course through PEPP unlimited will be completed by 05/20/24, and the in-person course will be completed by 06/04/2024. Finally, they are both enrolled in 2 hours of Fire Safety training through Tri-State Fire Safety, a recognized Fire Safety expert. The fire safety course will be completed by 05/10/2024. These enrollments complete the required 24 hours of training. Copies of all training certificates will be provided. The administrator is responsible for ensuring that copies of certificates are provided in a timely manner by 06/05/2024, at the latest. Going forward every 6 months beginning in June of 2024 the administrator and the designee will audit all staff records to ensure any deficiencies will be corrected within 30 days of each audit.

The administrator and designee are currently enrolled in the Long-Term Care Learning Center. They are both enrolled in 12.5 credits under the Long-Term Care Learning Center. As of 05/03/24, most of the 12.5 credits have been completed, and certificates are available upon request. In addition to this, they are both taking 5 online credits and six additional in-person credits, both under PEPP Unlimited. The online course through PEPP unlimited will be completed by 05/20/24, and the in-person course will be completed by 06/04/2024. Finally, they are both enrolled in 2 hours of Fire Safety training through Tri-State Fire Safety, a recognized Fire Safety expert. The fire safety course will be completed by 05/10/2024. These enrollments complete the required 24 hours of training. Copies of all training

64c - Annual Training (continued)

certificates will be provided. The administrator is responsible for ensuring that copies of certificates are provided in a timely manner by 06/05/2024, at the latest. Going forward every 6 months beginning in June of 2024 the administrator and the designee will audit all staff records to ensure any deficiencies will be corrected within 30 days of each audit.

Proposed Overall Completion Date: 06/05/2024

Licensee's Proposed Overall Completion Date: *06/05/2024*

Implemented ([redacted] - 06/12/2024)

65f - Training Topics

3. Requirements

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

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.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in the following topics during training year 7/1/2022 to 6/30/23:

- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Personal care service needs of the resident.*
- *Safe management techniques.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Plan of Correction ***Accept ([redacted] - 05/06/2024)***

All staff did receive trainings from Trainer [redacted] for 6hrs.([redacted] is a qualified trainer per DPW see attached credentials. All staff also received various training in house. see attached proof of training including canceled check for money paid to trainer(s). See also the training certificates

The immediate plan is to register with the proper training sources as approved by the Department. The information was not available for the surveyor at the time of inspection because it was not filed appropriately. Going forward, the audit method will be utilized to ensure that every 6 months the administrator and the designee will audit all staff records to ensure any deficiencies will be corrected within 30 days of each audit.

Proposed Overall Completion Date: 06/05/2024

Licensee's Proposed Overall Completion Date: *06/05/2024*

Implemented ([redacted] - 08/07/2024)

65g - Annual Training Content

4. Requirements

65g - Annual Training Content *(continued)*

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.

Description of Violation

Staff person A did not receive training in the following areas during training year 7/1/2022 to 6/30/23:

- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights*

Plan of Correction ***Directed ([redacted] - 05/06/2024)***

Staff person A training certificates were missing from the folder because they were filed incorrectly. The training were done by trainer [redacted] on 06/28/2023 - 6 hrs. see attached canceled check for training and qualification for training. Furthermore staff also received 4 hrs. training in other areas May 2023, Fire Safety 2 hrs. & New Resident Population 1 hr. see attached for a total of 13 hrs. for the training year.

Moving forward to prevent this error the assistant admin. will be in charge of setting up the training for staff by May of each year and will be responsible for posting the schedule where the staff can see it and the administrator will enforce this.

The immediate plan is to file the training certificates in the appropriate staff folders. The information was not available for the surveyor at the time of inspection because they were not filed appropriately. Going forward, the audit method will be utilized to ensure that every 6 months the administrator and the designee will audit all staff records to ensure any deficiencies will be corrected within 30 days of each audit.

Proposed Overall Completion Date: 06/30/2024

Directed plan of Correction 5/6/24 [redacted]

Only the overall completion date is directed. All steps in the home's plan shall be implemented by 6/5/24.

Directed Completion Date: *06/05/2024*

Implemented ([redacted] - 08/07/2024)

88a - Surfaces

5. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The second floor front bedroom floor has flooring, appearing to be linoleum, was peeling with a large 12 inch by 12 inch section missing between the bed and the dresser. Dirt and scuff marks are present on the floor near the dresser.

Plan of Correction ***Accept ([redacted] - 04/12/2024)***

Reason for this violation, the administrator /designee failed to monitor housekeeping and maintenance staff

88a - Surfaces (continued)

properly to ensure that the building was in proper and safe condition. Solution to the problem we replaced the entire floor on 4/3/2024, See attached pictures from 3/16/2024 and new flooring 4/3/2024. See also the canceled check for the cost to replace the floor. After the inspection we had an educational event with all staff where we covered the importance of proper cleaning. Safety for resident and staff missing flooring could have caused tripping or falls. Moving forward on a monthly basis admin/designee will be inspecting the entire buildings for issues and or continued compliance . Documentation will be kept by the admin/designee. We will also review the results of these inspections at monthly staff meetings. Attached proof of changes made pictures

Licensee's Proposed Overall Completion Date: *05/31/2024*

Implemented ([redacted] - 08/07/2024)

95 - Furniture and Equipment

6. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/14/2024, a bureau in a second-floor front bedroom was in disrepair, with four missing knobs and several drawers unable to open. The finish of the dresser was peeling and had scuff marks.

Plan of Correction ***Accept ([redacted] - 05/06/2024)***

On 3/15/2024 we removed the damage dresser from the room. (see pictures of said removal). We will be replacing it with a metal based chest .After the inspection we also covered the topic of unsafe furniture with all staff in and educational session. Again we stressed safety first when working with residents and staff.

The furniture was replaced on 04/20/24. The administrator was responsible for replacing them. Attached are photos of the furniture as well as payment receipts.

Proposed Overall Completion Date: 05/04/2024

Licensee's Proposed Overall Completion Date: *05/04/2024*

Implemented ([redacted] - 08/07/2024)

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

On 3/14/2024, the home's back door was difficult to open. The knob had to be turned in excess before the lock would release.

Plan of Correction ***Accept ([redacted] - 05/06/2024)***

On 3/14/2024 we were not aware that the inspector had an issue with the back door. Once we admit a new resident we take them on a tour of the home and show them how to open and close the doors along with other features of the home. Our locks are for safety and well being of residents and staff alike. If the door was mentioned staff would have demonstrated the techniques to the inspector. All resident and staff knows how to open and close the door

121a - Unobstructed Egress (continued)

properly .
The doorknob was replaced on 04/24/24. The administrator was responsible for replacing it. Attached are photos of the doorknob as well as payment receipt. The door has a doorbell as well, and the doorknob does not lock from the inside of the building.(pictures of the old and new locks are available)

Proposed Overall Completion Date: 05/20/2024

Licensee's Proposed Overall Completion Date: *05/20/2024*

Implemented (- 08/07/2024)

141a 1-10 Medical Evaluation Information

8. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation, dated , did not include special health needs, including whether the resident can safely use or avoid poisonous materials.

Resident #2's medical evaluation, dated did not include the resident's health status including cognitive functioning, or the resident's ability to self-administer medications.

Plan of Correction ***Directed (- 05/06/2024)***

On Resident #1, the special health need and whether or not the resident could safely avoid poisonous materials were not checked. Once the inspector pointed out the deficiency the administrator corrected the form and dated the areas 3/14/2024. (see attached). Resient#2 as shown on the Ma51 ,DME ,and assessment was not taking meds in See attached proof. To prevent this error in the future both the administrator/assistant admin will audit all resident folders on a quarterly basis. The outcome of the audit will be kept in the administrators records. Administrator and the designee will be auditing all resident files on 4/30/2024 using the section from 2600 regarding the requirements of a resident record.

As per the regulation, the home cannot correct the DME. The PCP corrected the DME on 04/29/24. Going forward the administrator will ensure that all forms are corrected on the onset to prevent future recurrence of this issue, and any adjustments will be conducted by the PCP only. All resident folders will be audited by the administrator and designee every 4 months beginning June 2024, and the anticipated audit should take approximately 5 business days to

141a 1-10 Medical Evaluation Information (continued)

complete. Any deficiencies will be corrected at that time by the administrator, and documentation of these corrections will be provided.

Proposed Overall Completion Date: 06/30/2024

Directed Plan of Correction 5/6/24 [redacted]

Immediately, the administrator shall send Residents' #1 medical evaluations back to the physician for completion or the home will have a new medical evaluation completed for the resident.

Directed Completion Date: *06/05/2024*

Implemented ([redacted] - 08/07/2024)

141b1 - Annual Medical Evaluation

9. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on [redacted].

Resident #3's most recent medical evaluation was completed on [redacted]

Repeated Violation: 12/27/2023

Plan of Correction ***Accept ([redacted] - 05/06/2024)***

Resident #2 most recent Medical evaluation and DME were completed on [redacted] *when the PCP did the annual visit. (see attached)*
Resident #3 most recent Ma51 and DME were also done on [redacted] *see attached copies. The Ma51 and DME for* [redacted] *were done for this resident on* [redacted] *see attached. These items were missing from the resident files because in the past the previous year forms were placed in a folder with the new form in anticipation of the PCP visit so it was easy for the PCP to see changes in weight and overall health of the resident when compared to the past year(s). As was documented before we will no longer remove any items from any resident file in anticipation of the PCP visit . The administrator/assistant administrator will copy items from the files in place such items in a binder for the PCP visit. Thus ensuring continued compliance of required items in each resident file.. Hopefully by using this system and quarterly audits we will no longer experience these errors.*

All direct care and administrative staff have been trained in the change in policy as of 04/24/24. The training was conducted by the administrator.

Proposed Overall Completion Date: 05/30/2024

Licensee's Proposed Overall Completion Date: *05/30/2024*

Implemented ([redacted] - 08/07/2024)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's most recent assessment was completed on [redacted]

Resident #3's most recent assessment was completed on [redacted]

Repeated violation: 12/27/2023.

Plan of Correction ***Accept ([redacted] - 05/06/2024)***

Resident #2 most recent Assessment was completed on [redacted]*. Resident #3 most recent assessment was done on* [redacted] *see attached copies. Our past practice was to place all annual or items in need of update in a special folder for the PCP. The administrator/assistant admin did not place the new and old items back in each resident file thus we received the violations. copies attached. Going forward the administrator/assistant administrator will prepare the needed information for each resident and place the items in a binder. Under no circumstance will we remove any required items from any resident file again. Administrator/assistant admin will audit all resident file each quarter to ensure compliance. The audit will be done by 4/30/2024 and every quarter afterwards.*

Every 3months in-house training will be conducted by the administrator .The training will be done using a chart showing required items for each folder per the regulations. Going forward, the audit method will be utilized to ensure that every 3 months the administrator and the designee will audit all resident records to ensure that any deficiencies will be corrected within15 days of each audit. The administrator and designee will be responsible for maintaining compliance. of the audit . The copy of the audit check list will be available

Proposed Overall Completion Date: 05/30/2024

Licensee's Proposed Overall Completion Date: *05/30/2024*

Implemented ([redacted] - 08/07/2024)