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

July 26, 2024

[redacted], ADMINISTRATOR
GREYSTONE COUNTRY ESTATES INC
424 DELAWARE ROAD
FREDONIA, PA, 16124

RE: GREYSTONE COUNTRY ESTATES
424 DELAWARE ROAD
FREDONIA, PA, 16124
LICENSE/COC#: 47098

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/02/2024 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: *GREYSTONE COUNTRY ESTATES* **License #**: *47098* **License Expiration**: *05/04/2024*

Address: *424 DELAWARE ROAD, FREDONIA, PA 16124*

County: *MERCER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *GREYSTONE COUNTRY ESTATES INC*

Address: *424 DELAWARE ROAD, FREDONIA, PA, 16124*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/17/1997* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *27* **Waking Staff**: *20*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/02/2024*

Inspection Dates and Department Representative

05/02/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *45* **Residents Served**: *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *9* **Are 60 Years of Age or Older**: *23*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *3*

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

05/02/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/02/2024*

06/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/12/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/13/2024*

Inspections / Reviews *(continued)*

06/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/12/2024*

07/26/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/12/2024*

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

85d - Trash Receptacles

1. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

There was a partially full, uncovered and unattended trash can in the shared Jack and Jill style bathroom in bedroom #106.

Plan of Correction ***Directed ([redacted] - 06/20/2024)***

THE ADMINISTRATOR, FLOOR SUPERVISOR, OWNER AND MAINTENANCE DIRECTOR WILL COMPLETE A NEW ENTIRE FACILITY AUDIT MONTHLY. WHICH INCLUDES SHOWER ROOM, PUBLIC RESTROOM, KITCHEN, FAMILY ROOM, AND OCCUPIED RESIDENT ROOMS. PLEASE SEE ATTACHED. THIS WILL BE KEPT IN THE DHS 2024 BINDER LOCATED IN THE MAIN OFFICE. THE AUDIT WAS COMPLETED ON 6/12/24 SEE ATTACHED. SEE ATTACHED PICTURE. ALL SHARED BATHROOMS HAVE COVERED TRASH CANS WITH LIDS SECURED. SEE ATTACHED. IN THE AUDIT SEE SECTION WHERE THE TRASH CANS ARE COVERED WITH LID. THIS AUDIT WILL BE COMPLETED ON A MONTHLY BASIS.

Proposed Overall Completion Date: 06/12/2024

Directed:
The administrator or designee placed the lid on the trash can on 6/12/24, as evidenced by a photo provided by the administrator.
[redacted] ***6/20/24***

Directed Completion Date: *06/12/2024*

Implemented ([redacted] - 07/26/2024)

89a - Water Pressure

2. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

The home did not have sufficient water pressure at the 2 bathroom sinks in the shared shower room. One sink was out of order and the other sink had no hot water.

89a - Water Pressure *(continued)*

Plan of Correction ***Accept ([redacted] - 06/20/2024)***

THE ADMINISTRATOR, FLOOR SUPERVISOR, OWNER AND MAINTENANCE DIRECTOR WILL COMPLETE A NEW ENTIRE FACILITY AUDIT MONTHLY. WHICH INCLUDES SHOWER ROOM, PUBLIC RESTROOM, KITCHEN, FAMILY ROOM, AND OCCUPIED RESIDENT ROOMS. PLEASE SEE ATTACHED. THIS WILL BE KEPT IN THE DHS 2024 BINDER LOCATED IN THE MAIN OFFICE. THE DATE THE FIRST AUDIT WAS COMPLETED WAS 6/12/24 BY THE FLOOR SUPERVIOR MARY DONAHUE. A SHOWER RENOVATION WAS COMPLETED ON 6/7/24 WHERE A NEW SINK WAS INSTALLED WITH WORKING HOT AND COLD WATER. SEE ATTACHED.

Licensee's Proposed Overall Completion Date: *06/12/2024*

Implemented ([redacted] - 07/26/2024)

102f - Towel/Washcloth/Soap

3. Requirements

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

Description of Violation

There were 7 unlabeled bottles of bodywash and shampoo on the shelf inside shower #1 in the shared bathroom.

There were 4 unlabeled bottles of bodywash and shampoo, and 1 container of shaving gel on the shelf inside shower #2 in the shared bathroom.

Plan of Correction ***Accept ([redacted] - 06/20/2024)***

A DAILY SHIFT CHECK LIST WILL BE MADE, AND COMPLETED DAILY TURNED INTO THE ADMINISTRATOR WEEKLY, AND KEPT IN THE OFFICE IN THE DHS 2024 BIND FOR REVIEW AND CONSISTENCY. SEE ATTACHED. ON 05/01/2024 THE BOTTLES WERE REMOVED. ON THE SHIFT CHECK LIST, ON 3RD SHIFT IT THE SHOWER ROOM IS CHECKED TO ENSURE THERE ARE CLEAN TOWELS, WASH CLOTHES AND THAT RESIDENT CAN BE SUPPLIED WITH BODY WASH. ON SECOND SHIFT IT SAYS THAT ALL PERSONAL ITEMS ARE CLEARED OUT AND RETURNED TO RESPONSIBLE PARTY. THIS IS COMPLETED DAILY, BY THE MED TECHS ON DUTY. THE ITEMS WERE REMOVED BY THE ADMINISTRATOR ON 5/1/24. THE CHECK LIST WILL BE COMPLETED BY MED TECHS WORKING THAT SHIFT. THE DATE IT WAS IMPIMENTED WAS WEEK ENDING 5/4/24.

Proposed Overall Completion Date: 06/12/2024

Licensee's Proposed Overall Completion Date: *06/12/2024*

Implemented ([redacted] - 07/26/2024)

132b - Safety Inspection/Fire Drill

4. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire drill and fire safety inspection observed by a fire safety expert was conducted on 9/19/23. The prior fire drill and fire safety inspection observed by a fire safety expert was conducted on 4/19/22.

132b - Safety Inspection/Fire Drill *(continued)*

Plan of Correction ***Directed (- 06/20/2024)***

THE ADMINISTRATOR HAS CONTACT THE FACILITIES FIRE EXTINGUISHER COMPANY. THEY WILL BE CONDUCTING A FIRE DRILLS, AND ENITRE STAFF IN SERVICE ON FIRE SAFETY, FIRE PREVENTION, AND PROPER USE OF FIRE EXTINGUISHERS, AS WELL AS A RE INSPECTION OF ENTIRE FACILITY. NO DOCUMENTATION TO ATTACH AT THIS TIME. WILL SEND UPON RECEIPT. NO DATE AS OF YET DUE TO THE EXPERT BEING OUT OF OFFICE. FACILITY WILL THEN CONTINUE TO PRACTICE MONTHLY FIRE DRILLS WITH TIME LISTED BY FIRE EXPERT. EXPECTED DATE OF DOCUMENTATION 6/7/24 AND WILL HAVE DATES OF INSERVICE AND FIRE INSPECTION TO REPORT. COMPANY CONTACTED IS CADMANS FIRE A SUPERVISED FIRE DRILL AND FIORE INSPECTION WAS COMPLETED ON 6/11/2024. PLEASE SEE ATTACHED. FIRE CHEIF/ EXPERT STATES THAT WE HAVE 5 MINUTES TO EVACUTE BUILDING. PLEASE SEE SIGNED LETTER GIVING VERIFICATION, AND EXEMPT FROM DHS 2 MINUTES AND 30 SECONDS. MONIOTRING FOR FUTURE DRILLS WILL BE DOCUMENTS ON DHS PROVIDED FIRE DRILL FORMS, THAT DEPARTMENT CAN SEE DURING ANNUAL RENEWALS IN THE FIRE BINDER LOCATED IN MAIN OFFICE. ALL STAFF WAS PRESENT TO REVIEW DRILL, AND POLICY AND ASK QUESTIONS ABOUT FIRE SAFETY TO FIRE DEPARTMENT.

Proposed Overall Completion Date: 06/12/2024

Directed:

By 6/27/24, the administrator or designee will develop and implement a process and procedure to ensure a fire drill is conducted by a fire safety expert annually. Documentation will be kept.

6/20/24

Directed Completion Date: *06/27/2024*

Implemented (- 07/26/2024)

132d - Evacuation

5. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drills conducted April 2023 - August 2023, the home did not have a maximum safe evacuation time specified in writing by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:
On 6/16/23 at 9:00 a.m. the fire drill was 2 minutes 45 seconds
On 8/16/23 at 2:00 a.m. the fire drill was 3 minutes

Plan of Correction ***Directed (- 06/20/2024)***

THE ADMINISTRATOR HAS CONTACT THE FACILITIES FIRE EXTINGUISHER COMPANY. THEY WILL BE CONDUCTING A FIRE DRILLS, AND ENITRE STAFF IN SERVICE ON FIRE SAFETY, FIRE PREVENTION, AND PROPER USE OF FIRE EXTINGUISHERS, AS WELL AS A RE INSPECTION OF ENTIRE FACILITY. NO DOCUMENTATION TO ATTACH AT THIS TIME. WILL SEND UPON RECEIPT. NO DATE AS OF YET DUE TO THE EXPERT BEING OUT OF OFFICE. FACILITY WILL THEN CONTINUE TO PRACTICE MONTHLY FIRE DRILLS WITH TIME LISTED BY FIRE

132d - Evacuation (continued)

EXPERT. EXPECTED DATE OF DOCUMENTATION 6/7/24 AND WILL HAVE DATES OF INSERVICE AND FIRE INSPECTION TO REPORT. COMPANY CONTACTED IS CADMANS FIRE [redacted] SUPERVISED FIRE DRILL WAS COMPLETED ON 6/11/2024.

Proposed Overall Completion Date: 06/12/2024

Directed:
By 6/27/24, the Administrator or designee will review the home's fire drill log monthly, to ensure all residents are evacuated within the safe evacuation time as determined by a fire safety expert. Documentation of reviews will be kept.

[redacted] ***6/20/24***

Directed Completion Date: *06/27/2024*

Implemented ([redacted] - 07/26/2024)

224a - Preadmission Screen Form

6. Requirements

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 #1 was admitted to the home on [redacted]; however, a preadmission screening form was not completed for the resident.

Plan of Correction ***Directed ([redacted] - 06/20/2024)***

THE PRE SCREEN FORM WILL NOW BE REQUIRED IN THE ADMISSION CHECK LIST, AS WELL AS IT WAS ADDED TO THE HOMES POLICY ON PAGE 14. BOTH DOCUMENTS LISTED ABOVE MUST BE INCLUDED IN RESIDENT FILE, SEE ATTACHED. THE PRE ADMIT SCREEN WAS ADDED TO THE ADMISSION CHECK LIST 6/11/2024. THE PRE ADMISSION CHECK LIST WILL BE ON NEW ADMISSIONS GOING FORWARD UPON APPROVAL IN THE POC. SEE ATTACHED PRE ADMIT SCREEN.

Proposed Overall Completion Date: 06/12/2024

Directed:
By 6/27/24 and monthly thereafter, the administrator or designee will audit all resident records to ensure a preadmission screening form is present. Documentation will be kept.

[redacted] ***6/20/24***

Directed Completion Date: *06/12/2024*

Implemented ([redacted] - 07/26/2024)

225a - Assessment 15 Days

7. Requirements

2600.

225a - Assessment 15 Days *(continued)*

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #1's assessment, dated [redacted] does not include the diagnoses of Vitamin D Deficiency and Degenerative Joint Disease Right Knee, as indicated on the resident's medical evaluation, dated [redacted]

Plan of Correction ***Directed ([redacted] - 06/20/2024)***

A POLICY WAS CREATED SEE PAGE 60 OF POLICY AND PROCEDURE, UNDER CONDITIONS TO ADMIT. RESIDENT MUST HAVE MEDICAL EVALUATION WITHIN 30 DAYS OF ADMISSION OR 15 DAYS AFTER BY THEIR CHOICE OF PHYSICIAN, IF NO EVALUATION IS DONE PRIOR TO ADMIT THE RESIDENT MUST PROVIDE PROOF OF APPOINT INCLUDING DATE, TIME, PHYSICIAN, AND RESPONSIBLE PARTY. SEE ATTACHED.

Proposed Overall Completion Date: 06/12/2024

Directed:

By 6/27/24, the administrator will review resident #1's most recent assessment to ensure all diagnoses indicated on the resident's most recent DME are indicated on the assessment.

[redacted] 6/20/24

Directed:

By 7/5/24, the administrator or designee will review all resident records to ensure there is a written initial assessment, completed within 15 days of admission, complete and present in each resident's record. Documentation will be kept.

[redacted] 6/20/24

Directed Completion Date: *07/05/2024*

Implemented ([redacted] - 07/26/2024)

225c - Additional Assessment

8. Requirements

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 2's assessment, dated [redacted] does not include the diagnoses of Joint Disorder, Magnesium Def, Hypo-Osmolality and Hyponatremia, Muscle Weakness, Symbolic Dysfunctions and Dysphagia, as indicated on the resident's medical evaluation, dated [redacted]

Plan of Correction ***Directed ([redacted] - 06/20/2024)***

A POLICY HAS BEEN ADDED PAGE 14 THAT MEDICAL EVAL MUST BE INITIALED IN THE CORNER BY THE ADMINISTRATOR BEFORE GOING INTO THEIR FILE FOR FINAL REVIEW. PLEASE SEE ATTACHED. MONTHLY AUDITS WILL BEGIN 7/1/24 AND WILL BE ON GOING DUE TO ADMISSIONS, AND IT NEEDING TO BE COMPLETED MONTHLY, THERE WOULD BE NO END DATE BECAUSE WE WOULD BE AUDITING THE SAME FILES OVER AND OVER AND OVER. PLEASE SEE ATTACHED NEW SUPPORT PLAN, ALONG WITH NEW DME FORM. THIS WILL BE

225c - Additional Assessment (continued)

DONE BY THE ADMINISTRATOR, OWNER, OR FLOOR SUPERVISOR

Proposed Overall Completion Date: 06/12/2024

Directed:
A new RASP for resident #2 was completed 6/12/24, and contains all diagnoses indicated on a new DME, dated 6/11/24, as evidenced by documentation submitted by the administrator.
[redacted] ***6/20/24***

Directed:
By 7/5/24 and monthly thereafter, the administrator or designee will audit all resident records to ensure an annual assessment is present, contains all diagnoses indicated on the resident's most recent DME, and completed timely. Documentation will be kept.
[redacted] ***6/20/24***

Directed Completion Date: 06/12/2024

Implemented ([redacted] - 07/26/2024)