

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

September 16, 2024

[REDACTED], ADMINISTRATOR  
GETZ PERSONAL CARE HOME INC  
1026 SCENIC DRIVE  
KUNKLETOWN, PA, 18058

RE: GETZ PERSONAL CARE HOME  
1026 SCENIC DRIVE  
KUNKLETOWN, PA, 18058  
LICENSE/COC#: 24050

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/14/2024 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: *GETZ PERSONAL CARE HOME* License #: *24050* License Expiration: *03/14/2025*  
 Address: *1026 SCENIC DRIVE, KUNKLETOWN, PA 18058*  
 County: *MONROE* Region: *NORTHEAST*

## Administrator

Name: *Erin Hnat* Phone: *5706291334* Email: *GETZPCH@PTD.NET*

## Legal Entity

Name: *GETZ PERSONAL CARE HOME INC*  
 Address: *1026 SCENIC DRIVE, KUNKLETOWN, PA, 18058*  
 Phone: *5706291334* Email: *GETZPCH@PTD.NET*

## Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/25/1991* Issued By: *PA L&I*

## Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *52* Waking Staff: *39*

## Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *05/14/2024*

## Inspection Dates and Department Representative

*05/14/2024 - On-Site: Megan Baronitis, Pamela Harris*

## Resident Demographic Data as of Inspection Dates

## General Information

License Capacity: *60* Residents Served: *50*

## Secured Dementia Care Unit

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

## Hospice

Current Residents: *2*

## Number of Residents Who:

Receive Supplemental Security Income: *6* Are 60 Years of Age or Older: *47*  
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *2* Have Physical Disability: *0*

## Inspections / Reviews

## 05/14/2024 - Full

Lead Inspector: *Megan Baronitis* Follow-Up Type: *POC Submission* Follow-Up Date: *06/15/2024*

## 07/02/2024 - POC Submission

Submitted By: *ERIN HNAT* Date Submitted: *07/25/2024*  
 Reviewer: *Ryan Yankowy* Follow-Up Type: *POC Submission* Follow-Up Date: *07/10/2024*

Inspections / Reviews (*continued*)

## 07/19/2024 - POC Submission

Submitted By: *ERIN HNAT*Date Submitted: *07/25/2024*Reviewer: *Ryan Yankowy*Follow-Up Type: *Document Submission* Follow-Up Date: *07/24/2024*

## 09/16/2024 - Document Submission

Submitted By: *ERIN HNAT*Date Submitted: *07/25/2024*Reviewer: *Ryan Yankowy*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

*The 55 PA code 2600. Regulations were not posted in the home on the date of inspection.*

## Plan of Correction

Accept (█ - 07/02/2024)

*\* DHS inspector provided administrator with copy of regulations and it was immediately placed in a conspicuous and public place in the home on 5/14/2024.*

*\* Administrator will check area of Department required information and postings weekly to ensure that nothing has been removed from the area and that all required postings are readily available to anyone who enters the facility.*

**Licensee's Proposed Overall Completion Date: 06/15/2024**

Implemented (█ - 08/05/2024)

## 60a - Staff/Support Plan

## 2. Requirements

2600.

- 60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

## Description of Violation

*The home currently serves 50 residents, including 2 residents currently receiving hospice services, 1 of which requires a 2 person assist to evacuate in the event of a fire. The home has 8 internal fire safe areas and a safe evacuation time of 8 minutes 6 seconds. On 5-1-24 to present only 2 staff members are scheduled in the home on the 10pm-6am shift. The home would not be able to meet the needs of the residents according to their Resident Assessment Support Plan in the event of an emergency between 10pm and 6am*

## Plan of Correction

Accept (█ - 07/18/2024)

*\* On █, Resident 1 was discharged from Getz Personal Care Home to a higher level of care by family and administration.*

*\* Going forward to maintain compliance, any resident who be is on hospice and becomes bed bound due to level of care will have proper documentation of care level and documentation that █ is not to be included in fire drills. During a fire drill a staff person will sit with the resident and not be included in the head count for evacuation and resident will not be included in the head count for evacuation. During the overnight hours, 10pm-6am, family will be responsible to provide additional care specifically for the hospice resident for the 8 hours that the care home is staffed with 2 Direct Care Staff. The additional care can either be from a family member who is staying at bedside or an outside agency staff who is paid for by the family. If family is unable to provide the additional care, the resident will transition out of the personal care home and to a higher level of care.*

*\* Bed bound status of resident will be determined by resident PCP, PCH Director of Nursing and Hospice agency nursing.*

*\* Ongoing compliance will be monitored by Administrator and Director of Nursing.*

**Licensee's Proposed Overall Completion Date: 07/11/2024**

Implemented (█ - 08/05/2024)

## 65d - Initial Direct Care Training

**3. 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**

*There is no documentation that Direct Care Staff Member C hired [REDACTED] and Direct Care Staff Member D hired [REDACTED] completed the Department Approved Direct Care training course.*

**Plan of Correction**

Accept ([REDACTED] - 07/18/2024)

*\* Direct Care Staff member C & D completed the required training per DHS.*

*\* To ensure compliance moving forward, upon initial hire of a Direct Care Staff person, they will receive information to log into and complete the Direct Care Staff Training prior to the end of the first week of training where they are still working with an existing staff member. If new hire is unable to complete this on their own due to lack of technology, they will be asked to complete the training in house on a computer at the facility prior to day 1 of their training.*

*\* Administrator will audit new hire training completion to ensure all documents, including Direct Care Staff Training, is completed prior to being unsupervised with residents.*

**Licensee's Proposed Overall Completion Date: 07/11/2024**

Implemented ([REDACTED] - 08/05/2024)

## 65i - Training Record

**4. Requirements**

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

**Description of Violation**

*There is no documentation of the date that Staff Member A completed training on safe management, resident rights, care for residents with dementia and cognitive impairments, and infection control.*

*There is no documentation of the date staff member Staff Member B completed annual training on Resident rights.*

*There is no documentation of the date that Staff Member E completed annual training on safe management, resident rights, care for residents with dementia and cognitive impairments, infection control*

**Plan of Correction**

Accept ([REDACTED] - 07/18/2024)

*\* Unable to fix current documentation due to dating of trainings from 2023.*

*\* Going forward, to ensure compliance a document was created by Administrator that staff shall document their name, date completed and sign upon completion of any Independent Readings being provided for trainings.*

*\* on 6/20/2024, a memo will be given to all staff upon receiving their paycheck giving updated procedures for completing any Independent Readings for this training year and all training years going forward.*

*The above memo will also be included with any new staff orientation/general training to ensure new staff are aware of how Independent Reading trainings are to be completed.*

**65i - Training Record (continued)**

\* Administrator will be responsible for ensuring continued compliance and use of the proper forms for documentation.

Licensee's Proposed Overall Completion Date: 07/11/2024

Implemented (█) - 08/05/2024)

**66b - Training Plan Content****5. Requirements**

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

**Description of Violation**

The homes 2024 training plan does not note the projected dates that training will be completed by staff.

**Plan of Correction**

Accept (█) - 07/02/2024)

\* Projected dates for any training previously given a TBD date have been added to the current training plan for 2024

\* Going forward to ensure compliance administrator will include a projected date of completion on the training plan and that date will be modified when an actual date has been determined by administration.

Licensee's Proposed Overall Completion Date: 06/15/2024

Implemented (█) - 08/05/2024)

**89b - Hot Water Temperature****6. Requirements**

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

**Description of Violation**

The water temperature in room # 136 was 125.4 degrees.

**Plan of Correction**

Accept (█) - 07/02/2024)

\* On 5/15/2024 Administrator had maintenance lower the water temperature in the hallway with higher temperature and had maintenance recheck all areas of the building to ensure temperatures were where they are required to be.

\* Maintenance checks water temperatures weekly to ensure that no temperatures exceed 120F. If temperatures exceed 120F water will be adjusted and temperature retaken to ensure compliance is being met.

Licensee's Proposed Overall Completion Date: 06/15/2024

Implemented (█) - 09/16/2024)

**101j2 - Bedroom Chairs****7. Requirements**

2600.

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

2. A chair for each resident that meets the resident's needs.

101j2 - Bedroom Chairs (continued)

Description of Violation

Room 205 is a double occupancy room and there was one chair in the room

Plan of Correction

Accept ( ) - 07/18/2024)

- \* A chair was placed in room 205 for resident on 5/14/2024 by housekeeping staff.
- \* During weekly cleaning of resident rooms, housekeeping will thoroughly examine each room and ensure that all required elements per DHS are present in the room and in clean, good, working condition.
- \* If an item is missing from the room, housekeeping will make administration aware and the item will be replaced on the same day is it appeared missing.
- \* Housekeeping Staff will be responsible for monitoring for continued compliance.

Licensee's Proposed Overall Completion Date: 07/11/2024

Implemented ( ) - 08/05/2024)

103e - Left Overs

8. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The refrigerator located in the kitchen had 1/2 of an egg salad sandwich and a container with a cinnamon roll in it. Neither item was labeled with a date.

2 open bags of cereal were found on tables in the home's dining room. The bags of cereal were not dated.

Repeated violation 3-28-23

Plan of Correction

Accept ( ) - 07/02/2024)

- \* Above items were labeled on immediately on 5/14/2024 by Administrator and kitchen staff to correct violation.
- \* All staff were reminded that any food in the kitchen, refrigerators and dining area are to be labeled and dated per regulations to ensure we are discarding food past the use by date.
- \* Signage was placed in the Kitchen Area on 5/15/2024 by administration to provide daily reminder that all items must be labeled and dated.
- \* Kitchen Manager and day shift cook will check kitchen area, refrigerators and dining area daily to ensure all items that require labeling and dating are labeled and dated and that any items past use by date are discarded and not used.

Licensee's Proposed Overall Completion Date: 06/15/2024

Implemented ( ) - 08/05/2024)

121a - Unobstructed Egress

9. Requirements

2600.

**121a - Unobstructed Egress (continued)**

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

**Description of Violation**

*During initial walkthrough on 5/14/24, there was a chair sitting in front of the emergency exit near room 113. Also, the emergency exit on the second-floor east door, does not securely close once opened.*

**Plan of Correction**

Accept (█) - 07/02/2024)

\* Chair in front of emergency exit was immediately removed on 5/14/2024 and second floor east door was repaired by maintenance on 5/15/2024.

\* Staff were individually reminded that exit doors cannot be blocked at any time due to fire safety and safe evacuation and re-educated again on 6/14/2024 by administrator and local fire department during Fire Extinguisher/Fire Safety/Emergency Preparedness Training.

\* Signage was placed on all exit doors to remind staff not to block exits by administration.

\* Administrator or manager on duty will do daily walk thru of building to ensure all emergency exits are clear for evacuation purposes.

Licensee's Proposed Overall Completion Date: 06/15/2024

Implemented (█) - 08/05/2024)

**131f - Fire Extinguisher Inspection****10. Requirements**

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

**Description of Violation**

*All the fire extinguishers in the building's inspections expired April 2024. The fire extinguisher in the boiler room's inspection expired April 2021.*

*Repeated violation 3-28-23*

**Plan of Correction**

Accept (█) - 07/02/2024)

\* All fire extinguishers inside and outside of the building were inspected on 5/14/2024.

\* To ensure continued compliance, administrator will do monthly checks on all fire extinguishers and document completion to be sure that inspection date is not missed.

\* Upcoming inspection reminder was placed on 2025 calendar to ensure inspection is not missed and inspection company will be contacted by administrator 1 month prior to inspection expiration to ensure inspection is completed in a timely manor.

Licensee's Proposed Overall Completion Date: 06/15/2024

Implemented (█) - 08/05/2024)

**132c - Fire Drill Records****11. Requirements**

2600.

132c - Fire Drill Records (continued)

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

Resident #1 is receiving hospice services and was not evacuated during the home's fire drill conducted on 4-30-24. The homes fire drill log notes there were 50 residents in the home and that 50 residents were evacuated however through staff interviews it was determined that the resident was not evacuated.

Plan of Correction

Accept ( [redacted] - 07/18/2024)

- \* Moving forward to ensure compliance, Resident #1 has was discharged to a higher level of care on [redacted] by family and Administration
- \* Administration is currently re-evaluating the hospice policy to ensure safety of any residents who are bed bound under Hospice services for evacuation policy and procedures.
- \* Any Hospice residents who are bed bound will have proper documentation from pcp to be excluded from fire drills and that will be document on fire drill log to show that they were not evacuated or part of the evacuation.
- \* Administrator will be responsible for monitoring continued compliance.

Licensee's Proposed Overall Completion Date: 07/11/2024

Implemented ( [redacted] - 08/05/2024)

132g - Fire Drills Days/Times

12. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The homes fire drills conducted from 9-5-23 through 4-30-24 were all conducted between the 21st and 31st day of the month.

Plan of Correction

Accept ( [redacted] - 07/02/2024)

- \* Moving forward to ensure compliance all fire drills will be at varies days, dates and times during each month and conducted by administrator.
- \* Fire drill log dates will be determined in advance annually and scheduled by administrator for administrator to be more aware of when a drill should be conducted to ensure dates, days and times are conducted variously throughout each month of the year.

Licensee's Proposed Overall Completion Date: 06/15/2024

Implemented ( [redacted] - 08/05/2024)

132h - Designated Meeting Place

13. Requirements

2600.

**132h - Designated Meeting Place (continued)**

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

**Description of Violation**

*Resident #1 is currently receiving Hospice Service and is actively dying as per interviews conducted with staff. Resident #1 was not evacuated during the home's fire drill conducted on 4-30-24. The home did not implement the statement of policy under regulation 2600.29.*

**Plan of Correction**

**Accept ( ) - 07/18/2024)**

*\*Resident #1 was discharged to a higher level of care on [REDACTED] by family and Administration.*

*\* Administration is currently re-evaluating the hospice policy to ensure safety of any residents who are bed bound under Hospice services for evacuation policy and procedures.*

*\* Any bed bound hospice residents will have proper documentation from PCP stating they are not to be included in the evacuation and that will also be noted on the fire drill documentation.*

*\* Administrator will monitor for continued compliance.*

**Licensee's Proposed Overall Completion Date: 07/11/2024**

**Implemented ( ) - 08/05/2024)**

**141a 1-10 Medical Evaluation Information****14. 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**

*The DME dated [REDACTED] for Resident #2 was incomplete. The required section pertaining special health needs or dietary needs was blank.*

**Plan of Correction**

**Accept ( ) - 07/18/2024)**

*\* DME was corrected and dated by administrator on 5/15/2024 to show completion of incomplete section.*

*\* To ensure continued compliance, Director of Nursing will audit all new and annual DMEs on date that they are received and prior to being placed in the chart to ensure that all sections are completed properly and all documentation that is needed is included.*

**Licensee's Proposed Overall Completion Date: 07/11/2024**

141a 1-10 Medical Evaluation Information (*continued*)

Implemented (█) - 09/16/2024)

## 185a - Implement Storage Procedures

## 15. 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**

*The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #5- At 7:56am on 5/2/24, the glucometer reading was 114 and the MAR, was incorrectly transcribed as 118.*

*Resident #6- At 3:53pm on 4/16/24 the reading in the glucometer was 330 but was incorrectly transcribed as 331 and at 4:13pm on 4/28/24 the reading in the glucometer was 356 but was incorrectly transcribed as 357.*

**Plan of Correction**

Accept (█) - 07/19/2024)

*\* All medication technicians who provided care on the days listed above were spoken to and re-educated immediately by the Director of Nursing to discuss the error and the importance of document the correct readings. All other medication technicians were also individually re-educated by the Director of Nursing on the importance of properly documenting the readings and all medication dispensed. Dates of re-education were 5/14/2024, 5/15/2024 and 5/16/2024.*

*\* To ensure compliance moving forward document was created to write down vital signs on paper then transferring to MAR. Director of Nursing and/or Administrative Assistant in the Nursing Department will do monthly audits on glucometers and the documented reading to ensure proper documentation and if any errors are discovered they will provide individual re-education to the medication technician responsible for the error. If errors with specific staff are ongoing, that staff person will be removed from dispensing medications and retrained in proper medication administration and diabetic care.*

*\* Director of Nursing will be responsible for monitoring to ensure compliance.*

**Licensee's Proposed Overall Completion Date: 07/11/2024**

Implemented (█) - 08/05/2024)

## 187a - Medication Record

## 16. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

4. Strength.

**Description of Violation**

*Resident #7 has a prescription for Triple Omega 3-6-9 2000MG Soft gels. The Medication Administration Record does not list the strength of the supplement.*

**Plan of Correction**

Accept (█) - 07/19/2024)

*\* Label was fixed and pharmacy contacted to update MAR on 5/14/2024 by the Director of Nursing.*

**187a - Medication Record (continued)**

\* To ensure compliance moving forward, Direct of Nursing will educate all medication technicians on proper labeling of medications to match MAR and to notify nursing of any difference between medication and MAR so it can be resolved.

\* Director of Nursing will be responsible for monitoring to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 07/11/2024

Implemented ( ) - 08/05/2024)

**227d - Support Plan Medical/Dental****17. 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 #2 was admitted to hospice services on [REDACTED]. Resident #1's Resident Assessment and Support Plan (RASP) dated [REDACTED] were not updated to include hospice services.

Resident #3 was admitted to PT services on [REDACTED]. However, Resident #3's RASP dated [REDACTED] were not updated.

Resident #1, #4 and #8 utilize bedrails on their beds. Resident #1's RASP dated [REDACTED] Resident #4's RASP dated [REDACTED] and Resident #8's RASP dated [REDACTED] does not include the required verbiage regarding use of the bed rail, including:

- The specific need for the device
- The intended use
- 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
- If a cover is required to meet FDA guidelines

Resident #1 is actively dying, according to the home's Administrator. No documentation is contained in Resident #1's RASP dated [REDACTED] indicating that Resident is not to be evacuated during fire drills and what staff responsibilities are for that resident during the fire drills.

Repeated Violation 3-8-23, 5-4-23

**Plan of Correction**

Accept ( ) - 07/19/2024)

\* All above Resident Assessment and Support Plans were updated accordingly by 5/17/2024.

\* Moving forward to maintain compliance, Director of Nursing will complete annual and updates on all RASPs and Administrative Assistant in the nursing office will audit them to ensure all information that is required is present and completed properly.

\* Any resident requiring PT/OT or hospice updates will be audited weekly by Administrative Assistant to ensure they have the correct information and updates required in their RASP.

\* Any resident with a bedrail will also have addendum for bedrail included with RASP and the RASP will be audited

227d - Support Plan Medical/Dental (continued)

by Administrative Assistant to ensure all paperwork is included.

\* Director of Nursing will be responsible to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 07/11/2024

Implemented (█) - 08/05/2024)

252 - Record Content

18. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #1, #3, #4's pictures contained in their file are more than 2 years old.

Repeated Violation 3-28-23, 5-4-23

Plan of Correction

Accept (█) - 07/19/2024)

\* Residents #1, 3 & 4 had new pictures taken by administrator and those pictures were placed in their charts and updated in emergency book and activity book on 5/17/2024

\* Administrator audited all resident admission dates to ensure all residents photographs were not outdated and any outdated photos were retaken and replaced in all charting that requires a photograph.

\* To ensure compliance, administrator will audit resident admission dates monthly to ensure that resident photos are up to date.

Licensee's Proposed Overall Completion Date: 07/11/2024

Implemented (█) - 09/16/2024)