pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **JEFFCO HEALTH SERVICES INC**
LEGAL ENTITY

To operate **PENN HIGHLANDS JEFFERSON MANOR P. C.**
NAME OF FACILITY OR AGENCY

Located at **417 RT. 28, BROOKVILLE, PA 15825**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **48**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 24**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **April 11, 2025** until **October 11, 2025**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **406241**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 11, 2025

[redacted], Administrator
Jeffco Health Services Inc.
417 Route 28
Brookville, Pennsylvania 15825

RE: Penn Highlands Jefferson Manor P.C.
License/COC #: 40624

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 23, 2024, October 1, 2024 and February 13, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 11, 2025 to October 11, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *PENN HIGHLANDS JEFFERSON MANOR P. C.* **License #:** *40624* **License Expiration:** *11/24/2024*

Address: *417 RT. 28, BROOKVILLE, PA 15825*

County: *JEFFERSON* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *JEFFCO HEALTH SERVICES INC*

Address: *417 RT. 28, BROOKVILLE, PA, 15825*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *02/09/1994* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *46* **Waking Staff:** *35*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *07/23/2024*

Inspection Dates and Department Representative

07/23/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served:** *29*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *second floor* **Capacity:** *24* **Residents Served:** *15*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *29*

Diagnosed with Mental Illness: *13*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *17*

Have Physical Disability: *2*

Inspections / Reviews

07/23/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/21/2024*

Inspections / Reviews *(continued)*

09/24/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/26/2024*

10/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/30/2024*

03/21/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 7/18/24, at approximately 2:00 am., resident #1 was found in resident #2's bedroom talking to resident #2. Resident #2 stated resident #1 came into [redacted] bedroom while [redacted] was sleeping, woke [redacted] up and asked to get into [redacted] bed with [redacted] and to allow [redacted] resident #1 to kiss [redacted] and to touch each other, causing resident #2 to be very upset and scared. The incident was reported to the home by resident #2 on 7/18/24, at approximately 9:00 am. However, this allegation of abuse was not reported to the local Area Agency on Aging as required by the Older Adult Protective Services Act.

On 7/22/24, at approximately 4:30 pm., while undressing resident #1 for a shower, staff observed an approximate 2" by 7" bruise on the right side of resident #1's back. Resident #1 said people were hitting [redacted] because they think [redacted] kissed somebody. However, this allegation of abuse was not reported to the local Area Agency on Aging as required by the Older Adult Protective Services Act.

Plan of Correction ***Accept ([redacted] - 10/16/2024)***

Training and education on reporting abuse will be provided to all facility staff 10/24/2024 at 1:30pm at the facility. The training will be conducted by [redacted] facility Administrator. [redacted] will keep record of the training in each staff file. Staff will sign off on their understanding of their duties to report abuse, neglect, or exploitation enacted upon a resident whether by a staff member, family member, or another resident.

Long term plans to eliminate this issue will include yearly education on OAPSA given by the Area Agency on Aging Ombudsman and this will be schedule by the facility administrator and the AAA office, and a record will be kept in each staff's file, maintained by the facility Administrator.

All reports of abuse, neglect, or exploitation will be reported to the appropriate agencies immediately and as required by the Older Adult Protective Services Act and this will be assured by [redacted]

Licensee's Proposed Overall Completion Date: *10/24/2024*

Implemented ([redacted] - 03/21/2025)

231b - Medical Evaluation

2. 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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation completed on [redacted] does not include a diagnosis of Alzheimer's disease or other dementia.

231b - Medical Evaluation (continued)

Resident #2 was admitted to the SDCU on [redacted] A medical evaluation was not completed within 60 days prior to admission.

Plan of Correction ***Accept ([redacted] - 10/16/2024)***

Training and education on admissions and required documentation will be provided to the Resident Care Coordinator (RCC) on 10/24/2024 by this Administrator, [redacted]

The administrator and RCC will discuss necessary admission documentation by an audit of files every six months, documented by the Administrator in an Excel spreadsheet. The first audit will occur 10/24/2024 and will continue every six months to include April 24, 2025 and October 24, 2025. If any issues are identified during each audit, the RCC will be trained on the required admission documentation again or she/he will be replaced.

Licensee's Proposed Overall Completion Date: *10/24/2024*

Not Implemented ([redacted] - 03/21/2025)

231c - Preadmission Screening

3. 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.

Description of Violation

Resident #2 was admitted to the SDCU on [redacted]. However, there is no written cognitive preadmission screening completed.

Plan of Correction ***Accept ([redacted] - 10/16/2024)***

Training and education on admissions and required documentation will be provided to the Resident Care Coordinator (RCC) on 10/24/2024 by this Administrator, [redacted]

The administrator and RCC will discuss necessary admission documentation by an audit of files every six months, documented by the Administrator in an Excel spreadsheet. The first audit will occur 10/24/2024 and will continue every six months to include April 24, 2025 and October 24, 2025. If any issues are identified during each audit, the RCC will be trained on the required admission documentation again or [redacted] will be replaced.

Licensee's Proposed Overall Completion Date: *10/24/2024*

Not Implemented ([redacted] - 03/21/2025)

231e - No Objection Statement

4. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the SDCU on [redacted] The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident #2 was admitted to the SDCU on [redacted] The home has no documentation that the resident and the

231e - No Objection Statement (continued)

resident's designated person have not objected to the admission.

Plan of Correction ***Accept (- 10/16/2024)***

A document of agreement to SDCU admission has been created as of 8/14/2024 and will be used ongoing for all SDCU admissions. The administrator will have this document will be a part of the admission packet when a resident is admitted to SDCU and this administrator is responsible for assuring it is filled out. Resident Care Coordinator will receive training on this document 10/24/2024. The facility administrator will complete this training and provide proof of it in the employee file.

An annual training of required admission documentation will be conducted by this administrator for the RCC and this annual training will be kept in training file as a long-term action plan to prevent the issue from arising again. The administrator will keep an electronic training log in the form of a spreadsheet indefinitely to assure all training requirements are completed.

Licensee's Proposed Overall Completion Date: *10/24/2024*

Not Implemented (- 03/21/2025)

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

Facility Information

Name: *PENN HIGHLANDS JEFFERSON MANOR P. C.* **License #:** *40624* **License Expiration:** *11/24/2024*

Address: *417 RT. 28, BROOKVILLE, PA 15825*

County: *JEFFERSON* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *JEFFCO HEALTH SERVICES INC*

Address: *417 RT. 28, BROOKVILLE, PA, 15825*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *02/09/1994* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *48* **Waking Staff:** *36*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *10/07/2024*

Inspection Dates and Department Representative

10/01/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served:** *31*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *2nd Floor* **Capacity:** *24* **Residents Served:** *15*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *29*

Diagnosed with Mental Illness: *13*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *17*

Have Physical Disability: *2*

Inspections / Reviews

10/01/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/09/2024*

Inspections / Reviews *(continued)*

12/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/19/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/09/2024*

01/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/19/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/24/2025*

03/21/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/19/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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

On 10/1/24 the home's regulation book was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 01/02/2025)***

This administrator posted the regulations, current license inspection summary and current license on the bulletin board at the entrance of the facility 11/9/2024.

A picture of the posting will be submitted with supporting documentation for this POC. This will remain posted and updated as more inspections occur by the administrator.

Every 6 months, this administrator and the RCC will do a walkthrough of the facility to assure the documents are posted and up to date. A record of the walk through and postings will be kept in an Excel document that tracks completion of the walk throughs.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented ([redacted] - 03/20/2025)

16b - Incident Policies

2. Requirements

2600.
16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home does not have a written policy on the prevention, reporting, notification, investigation and management of reportable incidents.

Plan of Correction ***Accept ([redacted] - 01/02/2025)***

This policy is and has been in effect within the facility. This administrator will submit the policy with supporting documentation and keep it within the building to be produced upon request. It is present as of 11/9/24 and will remain present within the facility.

At the time of the inspection, this Administrator was new to the facility and it was very disorganized. Since taking ownership of the facility, the documents have been made organized and accessible. The RCC was trained on the location of these documents 12/16/2024 and will be able to access and present them when the facility is inspected should the administrator not be present. This administrator will record the presence of these documents on a 6 month walk though inspection Excel sheet to assure they remain present and accessible.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented ([redacted] - 03/21/2025)

25a - Written Contract and Review

3. Requirements

25a - Written Contract and Review *(continued)*

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #2 does not have a resident/home contract completed.

Plan of Correction ***Accept (- 01/02/2025)***

An audit of resident files was completed 10/24/2024 by the administrator to identify missing documents for each file. A contract for all residents has been completed and is in each resident file. An audit of files will be completed every three months to assure all regulatory requirements are met for each file by this administrator. Next audit will 1/24/25 completed by administrator or designee.

The contract was signed by Resident #2's POA on admission and was misplaced by the RCC who completed it with the family. A copy will be submitted with the Supporting Documentation. It was completed with the POA and RCC on 8/12/2024.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (- 03/21/2025)

54a - Direct Care Staff

4. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 01/02/2025)***

Administrator will perform an audit of staff files 11/13/24. Any missing items will be collected by the administrator by 12/13/2024. The administrator or designee will audit staff files every three months to assure all necessary items are collected for files and regulatory requirements are met. This staff's diploma was put in file by 12/13/2024 and will be submitted with supporting documentation. Any missing documentation in all staff files was requested from staff after the audit 11/13/2024. Any missing documents will be obtained before 1/24/2025. The audit will be performed every 6 months and recoded on a spreadsheet along with requests for missing documentation.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented (- 03/21/2025)

65a - FS Orientation 1st Day

5. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.

65a - FS Orientation 1st Day *(continued)*

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, did not receive orientation in general fire safety and emergency preparedness.

Staff person B, hired [redacted] *did not receive orientation in general fire safety and emergency preparedness until* [redacted]

Plan of Correction ***Accept (- 01/02/2025)***

Administrator will perform an audit of staff files 11/13/24. Any missing items or trainings will be given or collected by the administrator by 12/13/2024. The administrator or designee will audit staff files every three months to assure all necessary items are collected for files and regulatory requirements are met.

Staff A left [redacted] *and will not be returning. Staff B received this training on* [redacted] *An audit of trainings from previous administrators for new hires has been performed. All staff will receive their trainings within the time frames of hire as outlined in the 2600 regulations. Any missing trainings for any staff within the facility that were hired before this Administrator took over will be completed before 1/24/2025.*

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (- 03/21/2025)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed [redacted] *40th scheduled work hour. However, this staff person did not complete any of the trainings required by this regulation.*

Plan of Correction ***Accept (- 01/02/2025)***

Administrator will perform an audit of staff files 11/13/24. Any missing items will be collected by the administrator by 12/13/2024. The administrator or designee will audit staff files every three months to assure all necessary items are collected for files and regulatory requirements are met.

Staff A left [redacted] *and will not be returning.*

The audit reveals where any missteps have been made in the former Administration's training program and anything incomplete will be completed by staff by 1/24/2025 and facilitated by this Administrator.

65b - Rights/Abuse 40 Hours *(continued)*

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented ([redacted] - 03/21/2025)

65d - Initial Direct Care Training

7. 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 member B, began providing unsupervised ADL services. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Administrator will perform an audit of staff files 11/13/24. Any missing items will be collected by the administrator by 12/13/2024. The administrator or designee will audit staff files every three months to assure all necessary items are collected for files and regulatory requirements are met.

Proposed Overall Completion Date: 12/16/2024

DIRECTED PLAN:
By 1/20/25: Staff person B, if still performing unsupervised ADL services with residents, will successfully complete the Department-approved direct care training course and pass the competency course. Documentation of successful completion and passing of the course shall be kept in the staff person's record.

Directed Completion Date: *01/20/2025*

Implemented ([redacted] - 03/21/2025)

65e - 12 Hours Annual Training

8. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person C received only 1 hour of annual training in training year 2023.

Direct care staff person D received only 1 hour of annual training in training year 2023.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

Administrator will perform an audit of staff files 11/13/24. Any missing items will be collected by the administrator by 12/13/2024. The administrator or designee will audit staff files every three months to assure all necessary items are collected for files and regulatory requirements are met.

Staff C and staff D are scheduled to complete their 2024 training hours, as well as the missing training hours for 2023 by 12/31/2024.

65e - 12 Hours Annual Training (continued)

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (- 03/21/2025)

65f - Training Topics

9. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
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 C and D did not receive any of the trainings required by this regulation during training year 2023.

Plan of Correction ***Accept (- 01/07/2025)***

Administrator will perform an audit of staff files 11/13/24. Any missing items will be collected by the administrator by 12/13/2024. The administrator or designee will audit staff files every three months to assure all necessary items are collected for files and regulatory requirements are met.

Administrator will update the Staff Training Plan to include all required trainings by 12/13/2024. All trainings will be scheduled and delivered by 3/15/2025.

Audits of staff files will continue by this administrator every three months to assure all training requirements are met.

Staff C & D are scheduled to have all 2024 trainings and all missing 2023 trainings completed by 12/31/2024.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 03/21/2025)

65g - Annual Training Content

10. 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.

65g - Annual Training Content *(continued)*

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 persons C and D did not receive any of the trainings required by this regulation during training year 2023.

Repeat Violation: 8/15/23

Plan of Correction ***Accept (- 01/07/2025)***

Administrator will perform an audit of staff files 11/13/24. Any missing items will be collected by the administrator by 12/13/2024. The administrator or designee will audit staff files every three months to assure all necessary items are collected for files and regulatory requirements are met.
Administrator will update the Staff Training Plan to include all required trainings by 12/13/2024. All trainings will be scheduled and delivered by 3/15/2025.
Audits of staff files will continue by this administrator every three months to assure all training requirements are met.

Staff C & D are scheduled to complete all 2024 and 2023 trainings by 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (- 03/21/2025)

92 - Windows

11. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 10/1/24 at 11:37 AM there was no screen on the window in bedroom #110.

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

This administrator will alert the Maintenace department of repairs necessary immediately 11/9/2024. Maintenace reports they will replace the screen by 11/10/2024.

This administrator will perform a walkthrough of the facility monthly, and report needed repairs to the Maintenace department. The Maintenace department will respond to the requests for repairs and provide the administrator will a completion date after the repair is made.

Licensee's Proposed Overall Completion Date: *11/10/2024*

Implemented (- 03/21/2025)

107b - Emergency Procedures

12. Requirements

2600.

107b - Emergency Procedures *(continued)*

107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

On 10/1/2024 the home did not have a written emergency procedure policy.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

This policy is and has been in effect within the facility. This administrator will submit the policy with supporting documentation and keep it within the building to be produced upon request. It is present as of 11/9/24 and will remain present within the facility.

At the time of the inspection, this Administrator was new to the facility and it was very disorganized. Since taking ownership of the facility, the documents have been made organized and accessible. The RCC was trained on the location of these documents 12/16/2024 and will be able to access and present them when the facility is inspected should the administrator not be present. This administrator will record the presence of these documents on a 6 month walk though inspection Excel sheet to assure they remain present and accessible.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented ([redacted] - 03/21/2025)

130h - Inoperable Smoke Detector

13. Requirements

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

This policy and procedure is and has been in effect within the facility. This administrator will submit the policy and procedure with supporting documentation and keep it within the building to be produced upon request. It is present as of 11/9/24 and will remain present within the facility.

In order to keep this policy organized and accessible, this Administrator will perform a walk through every 6 moths to assure the presence and accessibility of all policies relating to this chapter and record the presence in an Excel spreadsheet.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented ([redacted] - 03/21/2025)

132c - Fire Drill Records

14. Requirements

2600.
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

The fire drill record for the drills conducted on 8/31/24 and 9/30/24 do not include 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.

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

A form that reflects all regulatory requirements for a fire drill has been created as of 11/9/2024.

The Maintenace Director will be trained on this form 11/11/2024.

This form will be used for every fire drill and an audit of the fire drill record will be performed every three months by the administrator to assure all regulatory requirements are being met for each drill.

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

Not Implemented ([redacted] - 03/21/2025)

132f - Alternate Exit Routes

15. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

All fire drills from 10/29/23 through 9/30/24 use the same exit routes - Main first floor, side door 1st, and parking lot 2nd floor.

Repeat Violation: 8/15/23

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

A form that reflects all regulatory requirements (including the requirement for alternate exit routes to be used during fire drills) for a fire drill has been created as of 112/26/2024.

The Maintenace Director will be trained on this form and educated on this regulation 2600 132.f by 12/31/2024.

This form will be used for every fire drill and an audit of the fire drill record will be performed every three months by the administrator to assure all regulatory requirements are being met for each drill.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented ([redacted] - 03/21/2025)

141b1 - Annual Medical Evaluation

16. Requirements

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

Description of Violation

Resident #3's last 2 medical evaluations were completed on [redacted]

Resident #4's last 2 medical evaluations were completed on [redacted]

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

The resident care coordinator will be trained on this requirement on 11/11/2024.

An audit of files will be completed on 11/15/2024 by this administrator any missing items in the files will be completed by 12/15/2024.

An audit of files will be completed every three months to assure compliance with this chapter by this administrator.

Licensee's Proposed Overall Completion Date: *12/15/2024*

Implemented ([redacted] - 03/21/2025)

185a - Implement Storage Procedures

17. 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

On 10/7/24 resident #1's glucometer was not calibrated to the correct date or time.

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

All glucometers will be calibrated on 11/11/2024 by the resident care coordinator.

An audit of the medication cart will be performed monthly by the administrator to assure all glucometers are calibrated correctly by the resident care coordinator.

The resident care coordinator will document calibrations monthly to assure they remain calibrated.

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

Not Implemented ([redacted] - 03/21/2025)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident #1 is prescribed Lantus SoloStar. However, this medication was not administered on 10/5/24, 10/6/24 and 10/7/24 because the medication was not available in the home.

187d - Follow Prescriber's Orders (continued)

Repeat Violation: 8/15/23

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

A medication cart audit will be performed on 11/11/2024 by this administrator to assure all medications prescribed by the physicians are within the facility.

A training will be given on 11/19/2024 by this administrator to all staff so they understand reordering procedures for medications and what steps to take to remedy prescription issues.

An audit of medications will be performed monthly by this administrator or the resident care coordinator to assure all medications are being ordered on time and within the facility as prescribed.

Licensee's Proposed Overall Completion Date: *11/19/2024*

Implemented ([redacted] - 03/21/2025)

190a - Completion Medication Course

19. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C and staff person D, who currently administer medications to residents, have not had an annual practicum completed within the past 12 months.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

This administrator will complete the medication administration train the trainer course on 11/12/2024.

As of 11/12/2024, this administrator will assure all observations and practicums are completed within the time frames outlined by the medication administration course.

An audit of the requirements of the medication administration course will be completed monthly by this administrator to assure all practicums are completed in a timely manner.

Staff C & D received a medication observation as of 11/29/2024 and the record will be kept and followed by this administrator on Excel Spreadsheet to meet all medication administration requirements for all med certified staff under [redacted] supervision.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented ([redacted] - 03/21/2025)

191 - Resident Right to Refuse

20. Requirements

191 - Resident Right to Refuse *(continued)*

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

Upon admission to the facility, all residents will be educated on their right to refuse medication.

This administrator will assure all residents are educated upon admission as a part of the contract signed for admission to the facility.

As of 12/15/2024, and audit of resident files will be performed to assure compliance with this regulation.

Resident #2 was informed of this right upon admission [redacted] and it is included in [redacted] contract which will be submitted.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented ([redacted] - 03/21/2025)

223a - Description of Service

21. Requirements

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The home does not have a current written description of services and activities that the home provides.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

This description of services and activities is and has been in effect within the facility. This administrator will submit the policy with supporting documentation and keep it within the building to be produced upon request. It is present as of 11/9/24 and will remain present within the facility.

At the time of the inspection, this Administrator was new to the facility and it was very disorganized. Since taking ownership of the facility, the documents have been made organized and accessible. The RCC was trained on the location of these documents 12/26/2024 and will be able to access and present them when the facility is inspected should the administrator not be present. This administrator will record the presence of these documents on a 6 month walk though inspection Excel sheet to assure they remain present and accessible.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented ([redacted] - 03/21/2025)

224a - Preadmission Screen Form

22. 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

No preadmission screening was completed for resident #1, resident #2 or resident #4.

Plan of Correction ***Accept (- 01/07/2025)***

A training on this requirement will be given to the Resident Care Coordinator on 11/11/2024.

An audit of files will be performed 11/15/2024 by this administrator to assure compliance with this regulation.

An audit of files will be completed every three months by this administrator to assure compliance ongoing.

The Audits began 11/15/2024, as stated above, and will continue every three months. The next audit will be 3/15/2025.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (- 03/21/2025)

225a - Assessment 15 Days

23. Requirements

2600.
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, admitted on did not have an assessment completed until

Repeat Violation: 8/15/23

Plan of Correction ***Accept (- 01/07/2025)***

The administrator assured the assessment was completed 11/9/2024.

A training will be given to the resident care coordinator on 11/11/2024 on this requirement.

An audit of files will be completed by this administrator every three months to assure compliance with this regulation. Audits began 11/15/2024. The next audit will be 3/15/2025.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (- 03/21/2025)

225c - Additional Assessment

24. 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.

225c - Additional Assessment *(continued)*

3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's last 2 assessments were completed on [redacted]

Plan of Correction ***Accept (- 01/07/2025)***

Assessment was reviewed by the resident care coordinator and administrator on 11/9/2024.

A training will be given to the resident care coordinator on 11/11/2024 on this requirement.

An audit of files will be completed by this administrator every three months to assure compliance with this regulation. Audits began 11/15/2024. The next audit will be 3/15/2025.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (- 03/21/2025)

227g -Support Plan Signatures

25. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #4's assessment, dated [redacted]*, was not signed by the assessor.*

Plan of Correction ***Accept (- 01/07/2025)***

This assessment was signed 11/9/2024.

A training will be given to the resident care coordinator on 11/11/2024 on this requirement.

An audit of files will be completed by this administrator every three months to assure compliance with this regulation. Audits began 11/15/2024. The next audit will be 3/15/2025.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented (- 03/21/2025)

231b - Medical Evaluation

26. 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 #2, admitted 8/12/24, did not have a medical evaluation completed until 8/27/24.

Plan of Correction ***Accept (- 01/07/2025)***

The DME for this resident will be completed by 11/15/2024.

A training will be given to the resident care coordinator on 11/11/2024 on this requirement.

231b - Medical Evaluation (continued)

An audit of files will be completed by this administrator every three months to assure compliance with this regulation beginning 11/15/2024. The next audit will be 3/15/2025.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented ([redacted] - 03/21/2025)

231c - Preadmission Screening

27. 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.

Description of Violation

Residents #2 and #4, who reside in the SDCU, do not have written cognitive preadmission screenings completed.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

This administrator assured completion of these screenings 11/9/2024.

A training will be given to the resident care coordinator on 11/11/2024 on this requirement.

An audit of files will be completed by this administrator every three months to assure compliance with this regulation beginning 11/15/2024. Next audit will be 3/15/2025.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented ([redacted] - 03/21/2025)

231e - No Objection Statement

28. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #2 resides in the SDCU. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept ([redacted] - 01/07/2025)***

This administrator assured completion of objection statements as of 11/9/2024.

A training will be given to the resident care coordinator on 11/11/2024 on this requirement.

An audit of files will be completed by this administrator every three months to assure compliance with this regulation beginning 11/15/2024. The next audit is 3/15/2025.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented ([redacted] - 03/21/2025)

234a - Admission Support Plan

29. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2, admitted to the SDCU on 8/12/24, did not have a support plan completed until 8/23/24.

Plan of Correction ***Accept (- 01/07/2025)***

This administrator assured completion of support plans 11/9/2024.

A training will be given to the resident care coordinator on 11/11/2024 on this requirement.

An audit of files will be completed by this administrator every three months to assure compliance with this regulation beginning 11/15/2024. The next audit will be 3/15/2024.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented (- 03/21/2025)

251b - Record Entries Legible

30. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident #3's DME in the sections for both the date resident evaluated and date form completed.

Plan of Correction ***Accept (- 01/07/2025)***

All correction fluid was removed from the office supplies by this administrator as of 11/9/2024.

On 11/11/2024 the resident care coordinator will be educated on not using correction fluid on any documentation.

An audit of all files will be completed by this administrator monthly to assure no correction fluid is being used on documentation beginning 11/15.2024.

All staff will be educated on not using correction fluid within the facility by 12/31/2024.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 03/21/2025)

252 - Record Content

31. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

252 - Record Content *(continued)*

Description of Violation

Resident #2's record does not include a photo of the resident.

Resident #4's record does not include a photo of the resident.

Plan of Correction ***Accept (- 01/07/2025)***

An audit of files was completed 11/9/2024 by this administrator.

All resident photos will be added to the point click care system on 11/11/2024.

An audit of the point click care system will be completed monthly by the resident care coordinator to assure all photos are up to date beginning 11/15/2024 and will continue monthly.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (- 03/21/2025)

254b - Policy and Procedures

32. Requirements

2600.
254.b. Each home shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

Description of Violation

The 10/1/24 the home did not have policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

Plan of Correction ***Accept (- 01/07/2025)***

This policy is and has been in effect within the facility. This administrator will submit the policy with supporting documentation and keep it within the building to be produced upon request. It is present as of 11/9/24 and will remain present within the facility.

At the time of the inspection, this Administrator was new to the facility and it was very disorganized. Since taking ownership of the facility, the documents have been made organized and accessible. The RCC was trained on the location of these documents 12/16/2024 and will be able to access and present them when the facility is inspected should the administrator not be present. This administrator will record the presence of these documents on a 6 month walk though inspection Excel sheet to assure they remain present and accessible.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (- 03/21/2025)