



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 31, 2025

[Redacted]

Administrator
Irene Nelson

[Redacted]

RE: New Manor Personal Care Boarding Home
2211 West Venango Street
Philadelphia, Pennsylvania 19140
License #: 115531

Dear [Redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection July 2, 2024, July 25, 2024, and October 29, 2024 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 REVOKES your certificate of compliance 115530 dated April 20, 2024 to April 20, 2025 and 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) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from January 31, 2025 to July 31, 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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
132b	II	12	\$5	\$60	5 calendar days from mailing date of this letter

[REDACTED]

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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

[REDACTED]

CC:

[REDACTED]

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

Facility Information

Name: *NEW MANOR PERSONAL CARE BOARDING HOME* License #: *11553* License Expiration: *04/20/2025*
Address: *2211 WEST VENANGO STREET, PHILADELPHIA, PA 19140*
County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *IRENE NELSON*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *Other* Date: *05/01/2002* Issued By: *L&I*

Staffing Hours

Resident Support Staff: Total Daily Staff: *11* Waking Staff: *8*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *07/02/2024*

Inspection Dates and Department Representative

07/02/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* Residents Served: *11*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *11* Are 60 Years of Age or Older: *8*
Diagnosed with Mental Illness: *11* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

07/02/2024 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *Bypass Document
Submission*

11/20/2024 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/19/2024

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 7/2/2024, the home's current certificate of compliance, effective 4/20/2024, was not posted in a conspicuous or public place. An expired certificate, effective from 4/20/2022 to 4/20/2023, was posted.

Plan of Correction

Directed (█ - 08/09/2024)

Immediately: The administrator or designee shall check the home at least daily to ensure the current license, a copy of the current license inspection summary issued by the Department and a copy of Chapter 2600 regulations are posted in a public and conspicuous place in the home.

Directed Completion Date: 08/12/2024

Implemented (█ - 11/20/2024)

87 - Lighting

2. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On 7/2/2024, the home's porch light was missing a bulb.

Plan of Correction

Directed (█ - 08/09/2024)

Immediately: The administrator or designee shall repair or replace any inoperable light fixtures on the porch, or add additional source of light to ensure safe movement throughout the home. The administrator or designee shall begin a daily walkthrough of home to ensure sufficient lighting is maintained throughout the home. Any areas of non-compliance observed shall be corrected the same day.

By 8/14/24: The administrator shall develop a policy that includes a checklist for staff to review during walkthroughs of the home to ensure lighting outside and inside the home is sufficient.

Staff of the home shall be trained on policy within 5 days of creation of policy. Documentation of policy and staff training shall be kept and made available for Department review upon request. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 08/19/2024

Not Implemented (█ - 11/20/2024)

88a - Surfaces

3. Requirements

2600.

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

88a - Surfaces (continued)

Description of Violation

On 7/2/2024, the skylight in the bathroom nearest room 301 was covered in some type of black dirt or debris blocking most of the light.

Plan of Correction

Directed () - 08/09/2024

Immediately: The administrator or designee shall begin a daily walkthrough of home for 30 days to ensure all surfaces are clean, in good repair and free of hazards. Any areas of non-compliance observed shall be corrected the same day.

By 8/14/24: The administrator shall develop a policy that includes a checklist for staff to review during walkthroughs of the home to ensure surfaces are clean, in good repair and free of hazards.

Staff of the home shall be trained on policy within 5 days of creation of policy. Documentation of policy and staff training shall be kept and made available for Department review upon request. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 08/19/2024

Not Implemented () - 11/20/2024

89a - Water Pressure

4. 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

On 7/2/2024 at 9:58 am, the shower in the bathroom on the second floor closest to room 201 did not have sufficient water pressure for residents to shower.

Plan of Correction

Directed () - 08/09/2024

By 8/14/24: The administrator shall engage a licensed plumber to audit and repair any and all outstanding plumbing issues and document that all maintenance issues, both internal and external, throughout the home, are acknowledged and shall be repaired. All repairs shall be completed by 9/8/24. Documentation of the audits and the repairs shall be kept and made available for Department for review.

Directed Completion Date: 09/08/2024

Implemented () - 11/20/2024

132c - Fire Drill Records

5. 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

The fire drill record for the drill conducted on 6/28/24 does not include the amount of time it took for evacuation, the exit route used, the number of staff persons participating, problems encountered or whether the fire alarm or smoke detector was operative.

Plan of Correction

Directed (█ - 08/09/2024)

Immediately: The administrator shall monitor all fire drills and the fire drill record to ensure an unannounced fire drill is conducted at least once a month and is documented in the home's fire drill record which includes; the date, time, 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 activated. The administrator shall request the fire alarm activity records for the fire alarm monitoring company and maintain these records with the home's fire drill record

Directed Completion Date: 08/12/2024

Implemented (█ - 11/20/2024)

225c - Additional Assessment

7. Requirements

2600.

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

- 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.

225c - Additional Assessment (continued)

Description of Violation

Resident #1's most recent assessment was completed on [REDACTED]. In May 2024, staff person [REDACTED] the home's administrator, observed significant changes in the resident's behavior over several weeks, including a refusal to take medication and neglect of personal hygiene. The resident received no new assessment prior to their involuntary psychiatric admission on [REDACTED].

Resident #2's most recent assessment was done [REDACTED]

Plan of Correction

Directed ([REDACTED] - 08/09/2024)

By 8/14/24: The administrator or designee shall audit all resident assessments and support plans for accuracy and completion and complete an assessment and support plan for any resident's who has an out of compliance RASP. Documentation of the audit shall be kept and made available for Department for review.

Directed Completion Date: 08/14/2024

Not Implemented ([REDACTED] - 11/20/2024)

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

Facility Information

Name: *NEW MANOR PERSONAL CARE BOARDING HOME* License #: *11553* License Expiration: *04/20/2025*
Address: *2211 WEST VENANGO STREET, PHILADELPHIA, PA 19140*
County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *IRENE NELSON*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *Other* Date: *05/01/2002* Issued By: *PA Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *11* Waking Staff: *8*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *07/25/2024*

Inspection Dates and Department Representative

07/25/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* Residents Served: *11*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *11* Are 60 Years of Age or Older: *6*
Diagnosed with Mental Illness: *11* Diagnosed with Intellectual Disability: *3*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

07/25/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *10/25/2024*

11/20/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/18/2024

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

26a - Quality Management Plan

2. Requirements

2600.

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

Description of Violation

The home does not have a quality management plan.

Plan of Correction

Directed (█ - 09/24/2024)

Immediately: The home shall develop and implement a quality management plan that includes all of the required components by 2600.26b.

Within 10 days of receipt of the plan of correction: The home shall conduct a quality management review which includes a review of all of the required components in accordance with regulation 2600.26b. Documentation of the review shall be kept.

Directed Completion Date: 10/04/2024

Not Implemented (█ - 11/20/2024)

57d - Waking Hours

3. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 6/15/2024, a total of 11 hours of direct care was required. However, only 7.5 of the required hours, or 68 percent, were provided during waking hours.

On 6/22/24, a total of 11 hours of direct care was required. However, only 4 of the required hours, or 36 percent, were

57d - Waking Hours (continued)

provided during waking hours.

Plan of Correction

Directed (█) - 09/24/2024)

Immediately: The administrator shall review the schedule and residents' assessments and support plans at least weekly to ensure adequate staffing is scheduled. At least 75% of the required personal care service hours shall be available during waking hours and additional personal care service staffing hours shall be scheduled to meet the needs of the residents as specified in the resident's assessments, support plans and as needed to safely evacuate the residents in the event of an emergency.

Directed Completion Date: 09/25/2024

Implemented (█) - 11/20/2024)

63a - First Aid/CPR Training

4. Requirements

2600.

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

Description of Violation

On 6/22/2024, from 7:00am to 7:00pm, about 11 residents were present in the home. During this time there were no staff persons present in the home who were certified in first aid and CPR.

Plan of Correction

Directed (█) - 09/24/2024)

Immediately: The administrator or designee who schedules staff shall ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation is present in the home at all times.

Immediately: The administrator or designee shall review the schedule and staff working hours weekly to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation is present in the home at all times.

Directed Completion Date: 09/25/2024

Implemented (█) - 11/20/2024)

64c - Annual Training

5. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person █ the home's administrator, completed only 5.5 hours of Department-approved training in training year 2023.

64c - Annual Training (continued)

Plan of Correction

Directed () - 09/24/2024

Within 10 days of receipt of the plan of correction: An annual staff training plan shall be developed for the administrator which includes 24 hours of Department-approved training. Administrator training shall be monitored monthly and through the quality management process to ensure administrator has 24 hours of Department approved training annually.

Directed Completion Date: 10/04/2024

Not Implemented () - 11/20/2024

65a - FS Orientation 1st Day

6. 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.
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 B, whose first day of work was (), did not receive orientation on the following topics:

1. Evacuation procedures.
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.

Plan of Correction

Directed () - 09/24/2024

Within 10 days of the plan of correction: The administrator or designated staff person shall review all current staff person training records to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in general fire safety and emergency preparedness in accordance with regulation 2600.65a. Documentation of the training shall be kept in accordance with 2600.65i. Documentation of the audit shall be kept for Department review.

Directed Completion Date: 10/04/2024

Implemented () - 11/20/2024

65b - Rights/Abuse 40 Hours

7. 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 B began working in [REDACTED] and completed more than 40 scheduled work hours in [REDACTED]. However, this staff person did not complete training in the following topics:

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.

Plan of Correction

Directed ([REDACTED]) - 09/24/2024)

Within 10 days of receipt of the plan of correction: The administrator or designee shall review all training records for newly hired staff or staff hired within the past year to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions in accordance with regulation 2600.65(b). Documentation of the training shall be kept in accordance with 2600.65i. Documentation of the audit shall be kept for Department review.

Directed Completion Date: 10/04/2024

Implemented ([REDACTED]) - 11/20/2024)

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 zero hours of annual training in training year 2023.

Plan of Correction

Directed ([REDACTED]) - 09/24/2024)

Within 10 days of receipt of the plan of correction: The administrator or designated staff person shall monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required 12 hours of annual training during each established training year.

Directed Completion Date: 10/04/2024

Not Implemented ([REDACTED]) - 11/20/2024)

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 did not receive training in the following topics during training year 2023:

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.*

Plan of Correction

Directed (█) - 09/24/2024)

Within 10 days of receipt of the plan of correction: *The administrator or designee shall review all required staff training as part of the quality management review process to ensure all staff persons receive the required annual training in accordance with regulation 2600.65(f) and a record of all training is maintained in the staff records in accordance with 2600.65.*

Within 30 days of receipt of the plan of correction, direct care staff person C shall receive training in the following topics:

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.*

Documentation of education shall be kept in accordance with 2600.65i.

65f - Training Topics (continued)

Directed Completion Date: 10/24/2024

Not Implemented (█) - 11/20/2024)

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.
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.

Description of Violation

Staff person C did not receive training in the following areas during training year 2023:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Plan of Correction

Directed (█) - 09/24/2024)

Within 10 days of receipt of the plan of correction: The administrator or designee shall review all required staff training as part of the quality management review process to ensure all staff persons receive the required annual training in accordance with regulation 2600.65(g) and a record of all training is maintained in the staff records in accordance with 2600.65.

Within 30 days of receipt of the plan of correction, staff person C shall receive training in the following topics:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Directed Completion Date: 10/24/2024

Not Implemented (█) - 11/20/2024)

87 - Lighting

88a - Surfaces

12. Requirements

2600.

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

Description of Violation

The blue paint on the wall above the automatic hand-dryer in a second-floor bathroom is worn away, leaving a white area of about two feet wide and six inches tall, surrounded by a ring of additional white blotches. In the same bathroom, there is a piece of blue wall about six inches tall and three inches wide, a few inches above the line where the wall turns from yellow to blue, that appears to have been cut out.

Plan of Correction

Directed ([REDACTED]) - 09/24/2024)

Immediately: The administrator or designee shall begin a daily walkthrough of home for 30 days to ensure all surfaces are clean, in good repair and free of hazards. Any areas of non-compliance observed shall be corrected the same day.

Immediately: The administrator shall develop a policy that includes a checklist for staff to review during walkthroughs of the home to ensure surfaces are clean, in good repair and free of hazards.

Staff of the home shall be trained on policy within 5 days of creation of policy. Documentation of policy and staff training shall be kept and made available for Department review upon request. Documentation of education shall be kept in accordance with 2600.65i.

88a - Surfaces (continued)

Directed Completion Date: 09/30/2024

Not Implemented (█) - 11/20/2024)

130h - Inoperable Smoke Detector

14. 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

Directed (█) - 09/24/2024)

Immediately: the home develop a written procedure to be implemented when a smoke detector or fire alarm is inoperable.

Within 3 days of receipt of the plan of correction: The home shall educate all staff on the new procedure. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 09/27/2024

Not Implemented (█) - 11/20/2024)

132b - Safety Inspection/Fire Drill

15. 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 home has not had a fire safety inspection observed by a fire safety expert in the past two years.

Plan of Correction Repeated Violation: 5/9/23

Directed (█) - 09/24/2024)

Within 3 days of the plan of correction: A fire drill and fire inspection shall be conducted by a fire safety expert. Documentation of the fire drill and inspection shall be kept.

Directed Completion Date: 09/27/2024

Not Implemented (█) - 11/20/2024)

225a - Assessment 15 Days

16. 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.

225a - Assessment 15 Days (continued)

Description of Violation

Resident #1 was admitted to the home on [REDACTED] The initial assessment was completed [REDACTED]

Plan of Correction

Directed ([REDACTED] - 09/24/2024)

Immediately: The administrator or designee shall audit all resident assessments and support plans for accuracy and completion and complete an assessment and support plan for any resident's who has an out of compliance RASP. Documentation of the audit shall be kept and made available for Department for review.

Directed Completion Date: 09/25/2024

Not Implemented ([REDACTED] - 11/20/2024)

Facility Information

Name: *NEW MANOR PERSONAL CARE BOARDING HOME* License #: *11553* License Expiration: *04/20/2025*
Address: *2211 WEST VENANGO STREET, PHILADELPHIA, PA 19140*
County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: *IRENE NELSON*
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: *Other* Date: *05/01/2002* Issued By: *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *12* Waking Staff: *9*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Monitoring* Exit Conference Date: *10/29/2024*

Inspection Dates and Department Representative

10/29/2024 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	16	Residents Served:	12
Secured Dementia Care Unit			
In Home:	No	Area:	Capacity:
Residents Served:			
Hospice			
Current Residents: 0			
Number of Residents Who:			
Receive Supplemental Security Income:	12	Are 60 Years of Age or Older:	5
Diagnosed with Mental Illness:	12	Diagnosed with Intellectual Disability:	3
Have Mobility Need:	0	Have Physical Disability:	0

Inspections / Reviews

10/29/2024 - Partial
Lead Inspector: [Redacted] Follow-Up Type: *Document Submission* Follow-Up Date: *12/27/2024*

95 - Furniture and Equipment

1. Requirements

2600.

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

Description of Violation

On 10/29/24, at 10:12 AM, the toilet in the third floor middle bathroom was covered with plastic and was not in working order.

Plan of Correction

Directed () - 11/19/2024)

Within 30 days of receipt of the accepted plan of correction: A designee shall check the home daily to ensure furniture and equipment is in good repair, clean and free of hazards. Any hazards will be immediately corrected. If furniture or equipment is in disrepair and cannot be repaired immediately it will be immediately removed from service.

Directed Completion Date: 12/20/2024

Not Implemented () - 12/27/2024)

132f - Alternate Exit Routes

2. Requirements

2600.

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

Description of Violation

Front & Back is listed as the exit route used during the fire drills held from April 2024 thru July 2024.

Plan of Correction

Directed () - 11/20/2024)

Immediately: The administrator shall monitor fire drills and the fire drill record monthly to ensure alternate exits are used during fire drills.

Directed Completion Date: 11/22/2024

Not Implemented () - 12/27/2024)

141a - Medical Evaluation

3. 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.

Description of Violation

The medical evaluation, dated () for resident #1, admitted (), was not completed within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction

Directed () - 11/20/2024)

Within 5 days of the receipt of this plan of correction: The administrator shall develop and implement a tracking system to ensure medical evaluations are completed in accordance with regulation 2600.141(a).

Directed Completion Date: 11/26/2024

Not Implemented () - 12/27/2024)

224a - Preadmission Screen Form

4. Requirements

2600.

224a - Preadmission Screen Form (continued)

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.

Plan of Correction

Directed ([REDACTED] - 11/20/2024)

Within 30 days of receipt of the accepted plan of correction: The administrator or designated staff person shall create and implement a system to ensure all residents being admitted to the home have a preadmission screening completed in its entirety, to include an indication the home can meet the resident's needs.

Directed Completion Date: 12/20/2024

Not Implemented ([REDACTED] - 12/27/2024)

225a - Assessment 15 Days

5. 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

An assessment was not completed for resident #1, who was admitted to the home on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 11/20/2024)

Within 5 days of the receipt of this plan of correction: The administrator or designated staff person shall check all resident records to ensure a current assessment is completed, accurate and present in each resident's record.

Within 30 days of the receipt of this plan of correction: The administrator shall develop and implement a policy and procedures to ensure all residents have an assessment completed within 15 days of admission.

Directed Completion Date: 12/20/2024

Not Implemented ([REDACTED] - 12/27/2024)

