

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

December 6, 2024

[REDACTED]  
MERAKEY PENNSYLVANIA  
[REDACTED]

RE: MERAKEY PENNSYLVANIA  
1460 PEIFFERS LANE  
STEELTON, PA, 17113  
LICENSE/COC#: 31036

[REDACTED],  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/20/2024 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: MERAKEY PENNSYLVANIA License #: 31036 License Expiration: 03/28/2025  
 Address: 1460 PEIFFERS LANE, STEELTON, PA 17113  
 County: DAUPHIN Region: CENTRAL

**Administrator**

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

**Legal Entity**

Name: MERAKEY PENNSYLVANIA  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: Other Date: 03/24/2006 Issued By: Swatara Township

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 6 Waking Staff: 5

**Inspection Information**

Type: Full Notice: Unannounced BHA Docket #:  
 Reason: Renewal, Complaint, Incident Exit Conference Date: 08/20/2024

**Inspection Dates and Department Representative**

08/20/2024 On Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 6 Residents Served: 6  
 Secured Dementia Care Unit  
 In Home: No Area: Capacity: Residents Served:  
 Hospice  
 Current Residents: 0  
 Number of Residents Who:  
 Receive Supplemental Security Income: 6 Are 60 Years of Age or Older: 3  
 Diagnosed with Mental Illness: 6 Diagnosed with Intellectual Disability: 1  
 Have Mobility Need: 0 Have Physical Disability: 0

**Inspections / Reviews**

08/20/2024 - Full  
 Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 10/26/2024

Inspections / Reviews (*continued*)

## 11/06/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/29/2024  
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 11/12/2024

## 11/14/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/29/2024  
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 12/03/2024

## 12/06/2024 Document Submission

Submitted By: [REDACTED] Date Submitted: 11/29/2024  
Reviewer: [REDACTED] Follow Up Type: Not Required

## 16c Written Incident Report

### 1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

#### Description of Violation

On [REDACTED], the home contacted local police to report Resident [REDACTED] missing from the home. The local police brought Resident [REDACTED] back to the home at 3:20AM on [REDACTED]. The home did not report this incident to the department until [REDACTED].

The assessment and support plan, dated [REDACTED], for Resident [REDACTED] indicates the resident requires moderate supervision while in the home and community and defines moderate supervision as, "resident requires some supervision in the home and needs attendance when outside the home, and/or tends to wander." The plan is that staff will monitor Resident [REDACTED] hourly. On 3/18/24 at 11:52AM Resident [REDACTED] left the home and did not return until 7:14AM on 3/19/24. Upon returning home, staff recognized the resident appeared disheveled, their nose was bright red from the cold, nail beds had apparent bleeding, refused first aid, discoloration was noted on the resident's socks and upon removal of the socks their feet were bloody, returned home in different clothing that they left in, and was visibly swaying in the home. The home never reported this incident to the Department.

#### Plan of Correction

Accept ([REDACTED] - 11/06/2024)

Retraining on incident management and reportable incidents was provided to all staff on [REDACTED] by the Program Director, which included when, how, and where to report when an incident occurs. A memo was also provided to all staff on [REDACTED] about reporting incidents in a timely manner so the report can be filed within the 24-hour window

Beginning 11/1/24, all reportable incidents will be reported to the Program Director or Residential Director who will then complete and submit all internal and external required incident reports. All completed incident reports, which are completed by the Program Director or Residential Director, will be filed by the Program Director or Residential Director and maintained in a secure location. Once any required external and internal incident reports are completed, the Program Director or Residential Director will report the incident to the Regional Residential Director. The Regional Residential Director will complete the internal Critical Incident Report which captures if external reports have been completed and sent to the appropriate entity, including to the Department and submitted within the required time frame. Incident reports are reviewed as part of the monthly Performance Quality Improvement process by Program Leadership

Licensee's Proposed Overall Completion Date: 11/29/2024

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

## 65f Training Topics

### 5. 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.

65f - Training Topics (continued)

- 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 Member D and Staff Member F did not receive training in the following topics during the 2023 training year:

- Medication self-administration training.
- Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- Care for residents with [REDACTED] and [REDACTED].
- Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
- Personal care service needs of the resident.
- Safe management techniques.
- Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

**Plan of Correction**

Accept [REDACTED] 11/14/2024)

Staff Member D completed the 2024 annual training on 10/12/24 and is now in compliance for all required trainings. Staff Member F completed the 2024 annual training on 10/24/24 and is now in compliance for all required training. In addition to the above, all other program staff members have also completed the 2024 annual training and are up to date with this requirement. Beginning 11/15/24, once training is completed, staff are responsible for submitting training certificates and/or documentation to the Program Director or designee. Beginning 11/15/24, the Program Director or designee will ensure documentation is placed in the staff training file and uploaded into LMS. Beginning 11/15/24, in conjunction with the monthly PQI process, the Program Director or designee will complete a review to ensure all training records are stored. Any missing training certificates identified will be downloaded from LMS and stored in the staff file.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented [REDACTED] - 12/03/2024)

65g - Annual Training Content

**6. 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.

65g Annual Training Content (continued)

- 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

Direct care Staff Member D and Staff Member F did not receive training in the following topics during the 2023 training year:

- 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.
- Emergency preparedness procedures and recognition and response to crises and emergency situations. Resident rights.
- The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
- Falls and accident prevention.
- New population groups that are being served at the home that were not previously served, if applicable.

Plan of Correction

Accept ( [redacted] - 11/14/2024)

Staff Member D completed the 2024 annual training on 10/12/24 and is now in compliance for all required trainings. Staff Member F completed the 2024 annual training on 10/24/24 and is now in compliance for all required training. In addition to the above, all other staff members have also completed the 2024 annual training and are up to date with this requirement.

Beginning 11/15/24, once training is completed, staff are responsible for submitting training certificates and/or documentation to the Program Director or designee. Beginning 11/15/24, the Program Director or designee will ensure documentation is placed in the staff training file and uploaded into LMS. Beginning 11/15/24, in conjunction with the monthly PQI process, the Program Director or designee will complete a review to ensure all training records are stored. Any missing training certificates identified will be downloaded from LMS and stored in the staff file.

Licensee's Proposed Overall Completion Date: 11/15/2024

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

85a - Sanitary Conditions

7. Requirements

- 2600.
- 85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at approximately 10 AM, there were more than 10 fruit fly like gnats flying around the bathroom next to Residents [redacted] and [redacted] bedroom. During the inspection, the home's maintenance personnel reported to agents of the Department that the gnats are "drain flies" that continually appear due to the constant urination left on the bathroom floor. The drain flies were witnessed flying around the base of the toilet, where a small ring of urine was observed.

The carpeting outside the bathroom has dark stains as if the toilet overflowed; maintenance personnel confirmed the toilet has overflowed and they've tried to clean the carpet but has been unsuccessful.

85a - Sanitary Conditions (continued)

**Plan of Correction**

**Accept** [redacted] - 11/14/2024)

*Prior to licensing, the Program Director had placed a work order to request an assessment of the pest situation and the carpeting. Since then, multiple attempts have been made to remediate, including coordinating with an exterminator and purchasing various treatments. Facilities worked on identifying the source of the problem (scope of drains was completed by external company and result showed no cracks). On 10/23/24 an additional assessment was completed by Merakey exterminator and an external plumbing vendor. Gnats or flies were found around the toilets where there was moisture. The toilets were re- set, insecticide was sprayed and there will be regular inspections by Merakey's Exterminator. In addition, the Site Coordinator will begin on 11/11/24 to utilize the weekly walk-through checklist to document and review if any infestation (rodents or insects) exists. The Residential Director will provide training to the Program Coordinator by 11/11/24.*

*The carpet was replaced on 10/17 with laminate flooring by Touch Up Color Flooring.*

*The Program Director completed an entire house audit 11/8/24 and utilized the weekly walk-through checklist. The Program Director did not find any additional issues.*

*As of 11/8/24, the Psych Techs continue to complete the Daily Assignment Sheets that include reviewing unsanitary conditions within the house. The Program Director updated the weekly walkthrough on 11/8/24 to check for daily assignment sheet completion. The Residential Director will provide training to the Site Coordinator by 11/11/24. The Site Coordinator, or designee completes the weekly walk-through using a checklist to check for issues related to these items including additional unsanitary conditions starting 11/11/24. Any problems identified will be reported by the staff member completing the walk-through to the Program Director or designee within 24 hours.*

**Licensee's Proposed Overall Completion Date: 11/14/2024**

**Implemented** [redacted] - 12/03/2024)

85b - Infestation

**8. Requirements**

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

**Description of Violation**

*On [redacted] at approximately 10 AM, there were more than 10 fruit fly-like gnats flying around the bathroom next to Residents [redacted] and [redacted] bedroom. The fruit fly-like gnats were witnessed flying around the base of the toilet, and landing on the grab bar by the toilet, floor, walls and ceiling. Additionally, the fruit fly-like gnats were witnessed in Residents [redacted]s and [redacted] bedroom.*

85b Infestation (continued)

Plan of Correction

Accept [REDACTED] - 11/06/2024)

Prior to licensing, the Program Director had placed a work order to request assessment of the pest situation and the carpeting. Since then, multiple attempts have been made to remediate, including coordinating with an exterminator and purchasing various treatments. Facilities worked on identifying the source of the problem (scope of drains was completed by external company and result showed no cracks). On 10/23/24 an additional assessment was completed by a pest control vendor. Gnats or flies were found around the toilets where there was moisture. The toilets were re set, insecticide was sprayed, and there will be weekly inspections to ensure full remediation of the issue. The carpet was replaced on 10/17 with laminate flooring.

The Assistant Program Director or designee completes a weekly walk through using a checklist to check for issues related to these items, this is what lead to the initial work orders being submitted to correct the problems. These weekly walk throughs will continue. Any problems identified will be reported by the staff member completing the walk through to the Program Director or designee within 24 hours.

Licensee's Proposed Overall Completion Date: 11/29/2024

Implemented [REDACTED] 12/03/2024)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On [REDACTED] at 9:15 AM, the freezer part of the refrigerator/freezer next to the basement steps, housing resident's food, measured 4 degrees Fahrenheit. The home reported not having the freezer door open recently. Additionally, the home's temperature logs the freezer regularly record a temperature above 0 degrees Fahrenheit over the previous 3 months including: 10 degrees on [REDACTED] 4 degrees on [REDACTED], 8 degrees on [REDACTED] 5 degrees on [REDACTED], 11 degrees on [REDACTED], 10 degrees on [REDACTED] and [REDACTED]

On [REDACTED] at 9:45 AM, the upright GE freezer in the basement, measured 10 degrees Fahrenheit. The home's temperature log reflects regular temperatures over 0 degrees Fahrenheit including: 9 degrees on [REDACTED] 8 degrees on [REDACTED], 3 degrees on [REDACTED], 9 degrees on [REDACTED], 5 degrees on [REDACTED] 5 degrees on [REDACTED], 8 degrees on [REDACTED] and 7 degrees on [REDACTED]

Plan of Correction

Accept [REDACTED] - 11/14/2024)

Program Director replaced thermometers on [REDACTED]. The Refrigerator and Freezer Temperature Reading Log was updated by the Program Director to state "The freezer temp is required to be at or below 0 degrees and the refrigerator temp is required to be at or below 40 degrees. If there is any variance with these temperatures, contact management ASAP." This form is completed daily by overnight staff. If the freezer or refrigerator temperature exceeds the required temperature, staff will contact management as soon as possible and turn the temperature down. Upon staff notification, management will contact Merakey Facilities to assess the appliance immediately. Facilities (maintenance) will monitor, repair and replace as necessary. Staff will be trained by 11/15/24. Implementation will begin 11/15/24.

103f - Refrigerator/Freezer Temps (continued)

The weekly walk-through form was updated to include review of the Daily Temperature Log and will be implemented beginning 11/15/24. The Site Coordinator or Designee completes the walk-through using this checklist and will continue to do so with this new element added. Any problems identified are reported by the staff member completing the walk-through to the Program Director or designee within 24 hours.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented [redacted] - 12/03/2024)

107a - Emergency Preparedness

10. Requirements

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

During the [redacted] inspection, the home did not have the emergency preparedness plan for the local municipality and was not familiar with the local municipality's emergency preparedness plan.

Plan of Correction

Accept [redacted] - 11/14/2024)

ABH Residential Program Director delivered a copy of Dauphin County emergency preparedness plan to the home on 8/23/2024. The ABH Program Director placed the Dauphin County emergency preparedness plan in the emergency protocols and licensing folder in the entrance way on 8/23/2024. If changes are made to the plan the Program Director is responsible to add the updated copy.

All residential administrative staff will be trained on contents and location of plan by 11/11/24. The weekly walk-through form was updated to include review of the Dauphin County emergency preparedness plan and will be implemented after administrators are trained, by 11/11/24. The Program Coordinator or designee will complete the walk-through and if any problems are identified, the Program Director or designee will be notified within 24 hours.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [redacted] - 12/06/2024)

124 - Notice to Fire Department

11. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept [redacted] 11/06/2024)

Residential Director hand delivered the documentation directly to the local fire department on 8/22/24.

124 Notice to Fire Department (continued)

Moving forward, this document will be submitted annually by the Program Director or designee with an acknowledgement for verification of completion within 72 hours. The Residential Director has set an outlook calendar reminder for 1/28/2025 to have the written emergency procedures submitted to the local emergency management agency for review and included the Program Director and Regional Director on the invite. Moving forward, the Program Director will be responsible for setting up the outlook calendar reminder annually and obtain acknowledgement of receipt.

Licensee's Proposed Overall Completion Date: 11/29/2024

Implemented [REDACTED] - 12/03/2024)

125b - Combustible Restrictions

12. Requirements

2600.  
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On [REDACTED] at 9:55 AM, a full propane tank was attached to the grill in the backyard. The grill and propane tank were unlocked and accessible to all residents.

Plan of Correction

Accept [REDACTED] - 11/14/2024)

The grill was placed in the locked shed on the property on [REDACTED]

The grill will be stored in the locked shed at all times, except during use. Only staff will have access to the key to unlock the shed. The grill will be returned to the shed after each use by the staff. Review of the grill location was updated to the weekly walk through checklist by the Program Director on 11/8/2024 and will be implemented starting 11/11/24. The Program Coordinator will receive training by the ABH Residential Program Director on the adjustment by 11/11/2024. The Site Coordinator or designee completes the walk through using this checklist and will continue to do so with this new element added. Any problems identified are reported by the staff member completing the walk through to the Program Director or designee within 24 hours. A memo was provided by the Program Director to all staff on 11/11/24, instructing on the expectation that the grill must be stored in the lock shed when not in use.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [REDACTED] - 12/06/2024)

171b5 - First Aid Kit

15. Requirements

2600.  
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:  
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

171b5 First Aid Kit (continued)

**Description of Violation**

*The first aid kit in the Dodge Caravan used to transport residents does not include a thermometer.*

**Plan of Correction**

**Accept** [redacted] - 11/14/2024)

*A thermometer was added by the Program Director to the first aid kit on 8/20/24. All first aid kits are checked weekly during the weekly walk through by the Site Coordinator or designee. A list of all contents needed in the First aid kits was placed with all kits by the Program Director on 10/29/24. These items will be verified by the Site Coordinator or designee during the weekly walk through beginning 11/11/24. Any problems identified are reported by the staff member completing the walk through to the Program Director or designee within 24 hours. The Program Director shared memo with updates to staff on 10/28/24.*

**Licensee's Proposed Overall Completion Date: 11/14/2024**

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

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.

**Description of Violation**

*Resident [redacted] assessment, dated [redacted], does not include an assessment or support plan relevant to the resident's needs in orientation to time, place, and person, judgment, aggression, or hallucinations. However, the home documents on a monthly basis that Resident [redacted] has increased verbal and physical aggression towards staff and residents in the home, increased hallucinations, had to be transported to the emergency room for episodes of agitation, aggression, and delusions, continually leaves the property and does not return timely, refuses medications, was found with children's clothing in their laundry, expressed to staff they were a danger to themselves, and made comments about children, murder, and rape, and required police involvement multiple times.*

*Additionally, according to staff daily notes, Resident [redacted] like is to abide by a [redacted] restriction. However, the assessment and support plan dated [redacted] does not include this dietary need.*

*Resident [redacted], assessment reads, the resident doesn't have any assessed need or support with irritability, judgement, agitation, aggression, and hallucinations. However, according to daily documentation, staff record the following behavioral concerns that aren't included on the resident's assessment: isolating themselves more, expressed desire to stop taking medications, was drinking and swallowing mouthwash, slamming doors, cursing at occupants in the home, made a suicidal ideation, verbal aggression and attempted physical aggression with housemates.*

225a - Assessment 15 Days (continued)

**Plan of Correction**

Accept (█ - 11/14/2024)

A review of all resident assessments and support plans will be completed by the Program Director by 11/19/2024, and any updates needed will be completed.

Starting on 11/6/24, the ABH Residential Program Director and Program Director will complete the annual assessments and support plans in collaboration. The Program Director and/or designee will begin Quarterly Resident Assessment Service Plan (RASP) reviews to determine when the support plan needs to be updated due to a prolonged or significant change starting 11/19/2024 and continuing the beginning of every quarter thereafter. Reviews that occurred during that quarter will be discussed during that months PQI meeting. The ABH Residential Program Director, Program Director, Medical Coordinator, who are the only staff completing the assessments and support plans, received education on the expectation by 11/11/2024.

Licensee's Proposed Overall Completion Date: 11/29/2024

Implemented (█ - 12/06/2024)

252 - Record Content

17. Requirements

2600.

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

- 5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.

**Description of Violation**

Resident █ and Resident █ records do not include the name, address, telephone number and relationship of a designated person to be contacted in case of an emergency. Their record reads this information is, "n/a," (not applicable). However, the home reports all residents in the home have case managers to inform in emergency situations.

**Plan of Correction**

Accept (█ - 11/14/2024)

As of █ all resident face sheets have been updated to include the case manager as the emergency contact where necessary by the Program Director. The face sheet will be updated by management if changes occur. Moving forward, if there is no specific emergency contact for the resident at admission, the case manager will be noted as the emergency contact on the face sheet. Beginning 11/19/24, the Site Coordinator or designee will utilize the chart audit tool to check for timely and full completion of the Face Sheet. The chart audit will be completed monthly and will review at least █ residents. Beginning 11/19/2024, the results of the audit will be provided to the Program Director and Residential Director and will be reviewed during monthly Performance and Quality Improvement meetings.

The Program Director and the Medical Coordinator received training on the regulation and expectation by the Regional Director on 11/11/2024.

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

Implemented (█ - 12/06/2024)