

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

October 21, 2024

[REDACTED]  
PITTSTON HEAVENLY MANOR INC  
[REDACTED]

RE: PITTSTON HEAVENLY MANOR  
51 NORTH MAIN STREET  
PITTSTON, PA, 18640  
LICENSE/COC#: 21869

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/27/2024 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: PITTSTON HEAVENLY MANOR License #: 21869 License Expiration: 12/01/2024  
Address: 51 NORTH MAIN STREET, PITTSTON, PA 18640  
County: LUZERNE Region: NORTHEAST

**Administrator**

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

**Legal Entity**

Name: PITTSTON HEAVENLY MANOR INC  
Address: [Redacted]  
Phone: [Redacted] Email: [Redacted]

**Certificate(s) of Occupancy**

Type: C 2 LP Date: 05/10/1999 Issued By: L & I

**Staffing Hours**

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

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
Reason: Complaint, Incident Exit Conference Date: 08/27/2024

**Inspection Dates and Department Representative**

08/27/2024 On Site [Redacted]

**Resident Demographic Data as of Inspection Dates**

General Information			
License Capacity: 55	Residents Served: 52		
Secured Dementia Care Unit			
In Home: No	Area:	Capacity:	Residents Served:
Hospice			
Current Residents: 0			
Number of Residents Who:			
Receive Supplemental Security Income: 52	Are 60 Years of Age or Older: 39		
Diagnosed with Mental Illness: 50	Diagnosed with Intellectual Disability: 7		
Have Mobility Need: 0	Have Physical Disability: 2		

**Inspections / Reviews**

08/27/2024 - Partial		
Lead Inspector: [Redacted]	Follow-Up Type: POC Submission	Follow-Up Date: 09/20/2024
09/27/2024 - POC Submission		
Submitted By: [Redacted]	Date Submitted: 10/21/2024	
Reviewer: [Redacted]	Follow-Up Type: POC Submission	Follow-Up Date: 10/04/2024

Inspections / Reviews *(continued)*

10/11/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/21/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/18/2024

10/21/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/21/2024

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] at 2:30pm, Law enforcement came to the building due to a disturbance with a resident. The incident was not reported until [redacted] at 3:30pm.

Plan of Correction

Accept [redacted] - 10/11/2024)

The administrator is responsible for fixing the incident report error. Education of RCG and timely reporting given by Head administrator on [redacted]. The immediate response is that printed copies of the RCG for all reportable incidents 15a-d, 16b-f, frequently asked questions pgs. 175-177, Appendences pgs. 229-235. They are to be kept in the incident report book and referred to each time a incident occurs and in a timely manner as stated in the RCG (within 24 hours) of the incident. A copy of the completed incident report will directly be sent to head administrator and approved to sent to DHS. This ensures the report done, complete and sent according to regulations. The head administrator will review monthly the administrators incident report log at random days once a month to ensure compliance is maintained.

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

Implemented [redacted] 10/21/2024)

42c - Treatment of Residents

2. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], Resident [redacted] hit Resident [redacted] deliberately with their electronic scooter. No injuries occurred. Both Residents were evaluated and refused any additional medical care.

On [redacted], Resident [redacted] hit Resident [redacted] deliberately with their electronic scooter. Resident [redacted] then punched Resident [redacted] in the arm for hitting them with the scooter. No injuries occurred and both Residents were evaluated with no injuries observed and denied need for further medical care.

Plan of Correction

Accept [redacted] - 09/27/2024)

The incident occurred due to resident [redacted] impatient and not wanting to wait for the other resident to move. resident number [redacted] has received 30 day notice with appealment in court. Decision received from final court hearing July 16, 2024, resident [redacted] to vacate the premises on or after Sept. 1, 2024, If the resident does not leave on own accord must file with constable to remove from the property. Filed for removal on September 13, 2024. Constable came and served resident to vacate in 10 days or will escort off property. The resident was escorted off property for ending of eviction process on September 23, 2024, without further incident. The resident has been on 30 minute checks until discharge from the facility.

Resident [redacted] deliberately hit Resident [redacted] with the electronic scooter because [redacted] wanted him to move out of [redacted] way and [redacted] refused. Resident [redacted] was mad and was trying to get in the dining room first and the door closed due finishing set up for snack. Neither resident was going in the door at that time. [redacted] just wanted to be directly in

42c - Treatment of Residents (continued)

front and [redacted] to move out of the way and wait. Resident [redacted] hit [redacted] in the left knee with arm of [redacted] chair and drove the rest into the wall. Resident [redacted] was warned previously for driving the scooter with cause to harm to others and irrational when angry. The md was notified and the resident deemed able to walk around facility without the need of the scooter and d/c of order to have scooter in building for mode of transportation. The scooter was for use of outside travel only. The resident [redacted] continues with acting out and picking at staff 30 minute checks in place due to behaviors and 30 day notice received and upcoming eviction process due to disregard to others and no respect for them. Contract reviewed with resident and resident rights of all people. The med tech and PCA for each shift are responsible of the whereabouts of both residents and charting to be completed. The administrator to check for compliance to charting daily. The staff aware to report any and all incidents to head administrator/owner and administrator as soon as it occurs.

Licensee's Proposed Overall Completion Date: 09/26/2024

Implemented [redacted] - 10/21/2024)

227d Support Plan Medical/Dental

3. Requirements

2600.

227.d. Each home shall document in the resident s support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident s physician, physician s assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident [redacted] RASP, dated [redacted], was not updated to include 30-minute permanent status checks that were implemented by the home in [redacted].

Plan of Correction

Accept [redacted] - 09/27/2024)

The assistant administrator and administrator are responsible for updating the charts. The administrator made a transcription error and the information is on the previous RASP not on the most recent RASP. The violation was fixed on [redacted] on the correct RASP to reflect the update needed for the care plan. The administrator will double check chart within 24 hours of incident charting and new updates to ensure the documentation is on the proper RASP

Licensee's Proposed Overall Completion Date: 09/26/2024

Implemented [redacted] - 10/21/2024)