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

November 18, 2024

[redacted]
OUR HOME OF HOPE INC
[redacted]

RE: OUR HOME OF HOPE
223-225 CHERRY STREET
COLUMBIA, PA, 17512
LICENSE/COC#: 33322

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/17/2024 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: *OUR HOME OF HOPE* **License #**: *33322* **License Expiration**: *06/13/2025*

Address: *223 225 CHERRY STREET, COLUMBIA, PA 17512*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *OUR HOME OF HOPE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/14/1994* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *26* **Waking Staff**: *20*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *09/17/2024*

Inspection Dates and Department Representative

09/17/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served**: *26*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *7*

Diagnosed with Mental Illness: *16* **Diagnosed with Intellectual Disability**: *6*

Have Mobility Need: *0* **Have Physical Disability**: *3*

Inspections / Reviews

09/17/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/14/2024*

10/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/12/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/25/2024*

Inspections / Reviews *(continued)*

10/28/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/12/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/08/2024*

11/18/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/12/2024*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted], at 9:19AM, the following items were observed unlocked, unattended and accessible in the kitchen/medication area:
Resident [redacted] test result from [redacted]
UPMC Senior Care services visit dates for 2024.

Furthermore, the laptop on top of the med cart was also open to resident electronic records including Resident [redacted], Resident [redacted] and Resident [redacted] records.

Plan of Correction ***Accept [redacted] - 10/18/2024)***

- Administrator or Designee immediately removed resident information from bulletin board behind med cart on 9/17/2024.
- Administrator or Designee completed education with Staff on 9/19/2024 to include HIPPA Compliance training.
- Administrator or Designee will continue to monitor bulletin board to ensure resident information is secure also started Resident binder to ensure privacy.
- Administrator or Designee started weekly Audit 8/26/2024 and remains on-going.
- Administrator or Designee will included HIPPA Audit Tool in Quarterly meetings to ensure compliance next meeting scheduled 12/17/2024.

Licensee's Proposed Overall Completion Date: *10/30/2024*

Implemented [redacted] - 11/18/2024)

51 - Criminal Background Check

3. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Person B was hired on [redacted]. A criminal history check has not been completed.

Plan of Correction ***Accept [redacted] - 10/18/2024)***

-Administrator started 7/12/2024 and completed criminal background checks audit on 7/31/2024.
-Administrator will continue to use Staff Audit Tool for New Employee's.

51 Criminal Background Check (continued)

Administrator will review Staff Audit Tool Quarterly starting 7/12/2024 and remain on going.

Administrator will include Criminal Background Check Audit will be reviewed in Quarterly QA meeting, next meeting scheduled for 12/17/2024.

Licensee's Proposed Overall Completion Date: *10/16/2024*

Implemented [redacted] - 11/13/2024)

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:

Description of Violation

Staff Person B has a hire date of [redacted] However, this staff person did not complete the 1st day orientation training until [redacted] 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 ***Accept [redacted] - 10/18/2024)***

Administrator or Designee corrected date entry error on 9/17/2024.

Administrator or Designee will continue Staff Audit to ensure DHS Compliance and will be on going as of 9/17/2024.

Administrator or Designee will review with Staff at Quarterly QA meeting scheduled 12/17/2024.

Proposed Overall Completion Date: 10/30/2024

Licensee's Proposed Overall Completion Date: *10/30/2024*

Implemented [redacted] - 11/18/2024)

132c - Fire Drill Records

6. 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 home's fire drills on [redacted] and [redacted] document that "ALL" exits are used. Upon interviewing staff, fires are simulated in specific locations and simulate blocked exits. However, the home does not document this.

132c - Fire Drill Records (continued)

Furthermore, the fire drill that was conducted in [redacted] was initiated at 1:30. However, the home does not specify if it was AM or PM.

Plan of Correction ***Accept [redacted] - 10/18/2024)***

- Administrator or Designee have completed, reviewed, and education Universal Worker on Regulation Fire Drill and data entry on Fire Drill Logs on 6/30/2024 and again 9/17/2024.
-Administrator or Universal Worker will continue to conduct Monthly Fire Drill Log Audits to ensure compliance with DHS Regulatory Compliance Guide which started 6/13/2024.
- Administrator or Universal Worker will continue Monthly Audit to ensure compliance completed monthly started 9/17/2024.
- Administrator or Universal Worker will include Monthly Fire Drill Log Audit in Quarterly QA meetings to ensure compliance next meeting scheduled 12/17/2024.

Licensee's Proposed Overall Completion Date: *10/30/2024*

Implemented [redacted] - 11/18/2024)

133.1 - Exit Signs

7. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

On [redacted], at 10:59AM, the exit located by bulletin boards and resident restroom that leads to the back porch had no exit sign. This exit leads directly outside of the building and is used. The home currently serves 26 residents.

Plan of Correction ***Accept [redacted] 10/28/2024)***

- Administrator or Designee immediately put new Exit sign up on 9/17/2024.
** Administrator completed Exit Sign training with Universal Worker on 10/25/2024.*
** Universal Worker has started on 9/17/2024 and will continue to do walk through building daily.*
- Administrator or Designee will include Walk through Facility Audit in Quarterly QA meetings to ensure compliance, next meeting scheduled 12/17/2024.

Proposed Overall Completion Date: 10/25/2024

Licensee's Proposed Overall Completion Date: *10/25/2024*

Implemented [redacted] - 11/18/2024)

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

On [redacted] at 4:24PM, Resident [redacted]) did not have a prescription label attached to the medication.

On [redacted]4 at 4:25PM, Resident [redacted]) 100 had a pharmacy label attached without the current correct orders.
Resident [redacted] is prescribed the following sliding scale:
[redacted]
However, the following sliding scale was on the pharmacy label:
[redacted]

Resident [redacted] is prescribed [redacted] units sub-q in the evenings. However, the orders on the pharmacy label on the medication states to inject [redacted] units in the morning and [redacted] units in the evening.

Resident [redacted] is prescribed [redacted] capsules with orders to take 1 capsule by mouth routine. However, the orders on the pharmacy label on the medication states to take the medication 3 times a day, every 8 hours.

Plan of Correction ***Accept ([redacted] - 10/28/2024)***

- Administrator or Clinical Nurse Supervisor updated resident insulin bags to reflect correct order on 9/17/2024.
** Clinical Nurse Supervisor completed correct medication order education with Med Tech Staff at Med Tech meeting completed on 10/24/2024.*
** Administrator completed DHS regulations education with Med tech Staff at Med Tech meeting completed on 10/24/2024.*
- Administrator or Clinical Nurse Supervisor will include checking resident insulin bags to ensure correct order, during Medication Cart Compliance Audit and will continue to be done monthly.
- Administrator or Designee will continue to complete Medication Cart Compliance Audit, will be included in Quarterly QA meetings to ensure compliance, next meeting scheduled 12/17/2024.

Proposed Overall Completion Date: 10/31/2024

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented ([redacted] 11/18/2024)

185a - Implement Storage Procedures

9. 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.

185a Implement Storage Procedures *(continued)*

Description of Violation

Resident [redacted] has an order for [redacted] testing 4 times a day at 7:00AM, 12:00PM, 5:00PM and 8:00PM. The following discrepancies were observed between the blood sugar readings on the resident's glucometer and the resident's medication administration record (MAR):

On [redacted] at 7:00AM, the [redacted] reading is [redacted]. However, the MAR has a documented reading of [redacted].
On [redacted] at 12:00PM, the [redacted] reading is [redacted]. However, the MAR has a documented reading of [redacted].
On [redacted] 12:00PM, the [redacted] reading is [redacted]. However, the MAR has a documented reading of [redacted].
On [redacted] 7:00AM, the [redacted] reading is [redacted]. However, the MAR has a documented reading of [redacted].
On [redacted] 8:00PM, the [redacted] reading is [redacted]. However, the MAR has a documented reading of [redacted].
On [redacted] at 7:00AM, the MAR has a documented reading of [redacted]. However, this reading is not in the [redacted].
On [redacted] at 5:00PM, the [redacted] reading is [redacted] However, the MAR has a documented reading of [redacted].

Repeated Violation 05/02/2023

Plan of Correction ***Accept [redacted] - 10/28/2024)***

** Administrator or Clinical Nurse Supervisor completed training with Med Tech Staff on 8/30/2024, and at Med Tech Meeting completed on 10/24/2024.*

Administrator will continue to completed MAR Audits monthly started 7/1/2024.

Clinical Nurse Supervisor will complete Medication Cart Compliance Audit started 7/23/2024 and will continue on going.

Administrator or Designee will be included in Monthly MAR's with Staff Training Material in Quarterly QA meetings to ensure Compliance, next meeting scheduled 12/17/2024.

Proposed Overall Completion Date: 10/31/2024

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented [redacted] - 11/18/2024)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident [redacted] has an order for blood sugar testing 4 times a day for diabetes at 7:00AM, 12:00PM, 5:00PM and 8:00PM. However, the resident did not have blood sugar testing completed on 08/13/2024 at 12:00PM, 08/19/2024 at 12:00PM, 08/20/2024 at 8:00PM and 08/31/2024 at 8:00PM.

Resident [redacted] is prescribed [redacted] unit/ML with the following sliding scale order:
3 times a day at 7:00AM, 12:00PM and 5:00PM before meals.

[redacted]

On 09/10/2024 at 7:00AM, Resident [redacted] had a blood sugar level of [redacted] and was administered [redacted] Units.

187d - Follow Prescriber's Orders (continued)

Resident [redacted] is prescribed [redacted] u/m inject [redacted] units sub-q in the mornings for [redacted] From 09/10/2024 through 09/15/2024, this medication was not administered.

Resident [redacted] has an order for [redacted] u/m inject [redacted] units under the skin every morning for [redacted] On 09/10/2024 at 7:00AM, this medication was not administered.

Resident [redacted] is prescribed [redacted] testing twice a day for [redacted]. However, the resident did not have blood sugar testing completed on 08/03/2024 at 07:00AM.

Resident [redacted] is prescribed [redacted] tablet with orders to take 1 tablet by mouth 30 mins before breakfast on an empty stomach with 4oz of water for [redacted]. However, this medication was not administered from 09/08/2024 through 09/11/2024 because it was not available in the home.

Plan of Correction ***Accept [redacted] - 10/18/2024)***

- Administrator or Clinical Nurse Supervisor immediately updated Insulin bags to reflect doctor order(s) are correct on each Diabetic residents bag(s) completed 9/17/2024.
- Administrator or Designee completed education with Med Tech's on proper medication administration and compliance with emphasis on Diabetic Training and Sliding Scales training completed 9/19/2024.
- Administrator or Designee will continue to complete Monthly Medication Cart Compliance Audit started 7/23/2024 and will continue on-going.
- Administrator or Designee will included Med Tech Training material, Med Cart Audits in Quarterly QA meetings to ensure compliance, next meeting scheduled 12/17/2024.

Licensee's Proposed Overall Completion Date: *10/30/2024*

Implemented [redacted] - 11/18/2024)