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

November 19, 2024

[redacted], ADMINISTRATOR
UMH PA CORP
[redacted]

RE: WESLEY VILLAGE
215 ROBERTS ROAD
PITTSTON, PA, 18640
LICENSE/COC#: 24188

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/01/2024, 10/03/2024 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *WESLEY VILLAGE* **License #**: *24188* **License Expiration**: *08/15/2025*

Address: *215 ROBERTS ROAD, PITTSTON, PA 18640*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *UMH PA CORP*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/02/2000* **Issued By**: *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *10/03/2024*

Inspection Dates and Department Representative

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

10/03/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *157* **Residents Served**: *66*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

10/01/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/31/2024*

11/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/13/2024*

Inspections / Reviews *(continued)*

11/14/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/19/2024*

11/19/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2024*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

During physical site inspection on 10/1/2024, it was discovered that the carbon monoxide detector, located in the laundry room on the ground floor of Myers Manor, did not indicate when the batteries were last changed. The Care Facilities Carbon Monoxide Standards Act requires the batteries to be changed and dated annually.

Plan of Correction ***Accept (- 11/06/2024)***

The Plant Operations Team currently keeps Monthly audits of all CO2 Detectors. Re-education on labeling of CO2 detectors that are not hard-wired occurred to follow The Care Facilities Carbon Monoxide Standards Act of the batteries to be changed and labeled annually. The Plant Operations Team will continue to do monthly audits of the Carbon Monoxide Detectors to ensure continued compliance with this regulatory requirement.
Completion Date: 10/7/2024
The Administrator and/or will conduct monthly audits of the Carbon Monoxide Detectors to monitor Compliance with this Regulatory requirement for 3 months and as needed thereafter. Results will be discussed in QAPI.

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

Implemented (- 11/18/2024)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On at during a monthly glucometer audit conducted by the home, it was discovered that Resident #3, Resident #4 and Resident #5 had their glucometers used for the incorrect resident, creating a contamination situation for all residents involved.

Plan of Correction ***Accept (- 11/06/2024)***

Upon Identification that Resident # 3,4 and 5 glucometers were used on the incorrect residents. The residents, residents' representatives, the resident's medical providers and the commonwealth were immediately notified. All recommendations from the commonwealth were followed to ensure the safety and well-being of the residents involved. Administration immediately took the effected glucometers out of service and replaced them with new glucometers for each resident. All staff who participate in the provision of assistance with blood glucose testing were immediately re-educated regarding the prohibition of sharing blood glucose monitoring equipment between residents and the importance of ensuring each blood glucose monitor is used for the correct resident by verifying the residents name on the device before use.
Completion Date: 9/06/2024
Administrator and/or designee will continue monthly observational audits to ensure each blood glucose monitor is used for the correct resident for 12 months and as needed thereafter to maintain continued compliance. Results will be discussed in QAPI review.

85a - Sanitary Conditions *(continued)*

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

Implemented ([redacted] - 11/18/2024)

103i - Outdated Food

3. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

During 10/3/2024 onsite inspection, it was noted that in the kitchen dry storage area, there was a can of Harvest Value Cheese that was dented.

Plan of Correction ***Accept ([redacted] - 11/06/2024)***

The Dietary Supervisor and related staff were re-educated on the regulatory requirement on outdated food and/or dented cans. The Administrator and/or designee will conduct monthly audits to monitor compliance with this regulatory requirement for 3 months and as needed thereafter. The results will be discussed in QAPI.
Completion Date: 10/7/2024

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

Implemented ([redacted] - 11/18/2024)

131f - Fire Extinguisher Inspection

4. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

During 10/1/2024 onsite inspection, the fire extinguishers outside room 213, 217 and in the second floor stairwell of South Myers Manor, were due to be inspected 09/2024, and were beyond the annual inspection date.

Plan of Correction ***Accept [redacted] - 11/06/2024)***

The Plant Operations Team will continue with their monthly audit of the fire extinguishers. Cintas, whom is a contracted service provider of the fire safety systems was made aware of the extinguishers that were not corrected from their last visit. The Plant Operations team was re-educated on the fire extinguisher inspection process. Immediate action was taken to ensure compliance with this regulatory requirement.
Completion Date: 10/7/2024
The Administrator and/or designee will conduct monthly observational audits for 6 months and as needed thereafter. Results will be discussed during QAPI review.

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

Implemented ([redacted] - 11/18/2024)

132e - Fire Drill Sleeping Hours

5. Requirements

132e Fire Drill Sleeping Hours *(continued)*

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

During 10/3/2024 inspection, the home's monthly fire drill log was reviewed. It was noted that the home's sleeping hour fire drill, held on 3/14/2024, was conducted at 10:45pm. Seven staff were interviewed, and all staff members stated that some residents stay up until 11pm watching television.

Plan of Correction ***Accept ([redacted] - 11/06/2024)***

The Administrator and Plant Operations Director were re-educated on the drill that is conducted every 6 months during sleeping hours. Drills during sleeping hours will be conducted on random days after 12am but before 6am. This will ensure compliance with this regulatory requirement.
Completion Date: 10/7/2024.
The Administrator and/or designee will conduct an audit at the next 6 month sleeping hours drill to maintain compliance with this regulatory requirement. Results will be discussed during QAPI review.

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

Implemented ([redacted] - 11/18/2024)

133.2 Exit Signs Direction

6. Requirements

2600.
133.2. Exit Signs The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

During 10/1/2024 physical site inspection, it was noted that the kitchen, located on the ground floor of the Anderson Building, has three doors. All doors lead to exterior exits, however none of the doors are equipped with an exit sign indicating an egress route.

Plan of Correction ***Accept [redacted] - 11/14/2024)***

One of the 3 doors referenced above was labeled from the surveyors recommendations of putting "Not An Exit " signage on one particular door. I did not understand as it did exit the kitchen area. It does exit the kitchen and an exit sign is installed on the door. The space was gone through again with an install of an illuminated Exit sign above the door that is the main exit. The other 2 doors lead to Exits and Exit signage was installed on the door.

"All 3 doors in the Anderson kitchen were equipped with the proper signage. Two of the doors had exit signs installed. The 3rd door was equipped with signage that states "NOT AN EXIT". An audit of all the exits and interior doors was completed by the Administrator and the Plant Operations Team to ensure compliance with this Exit Sign requirement."
Completion Date: 10/7/2024
The Administrator and/or designee will conduct monthly audits on "EXIT" Signage to maintain this regulatory requirement. Results will be discussed during the QAPI review.

133.2 - Exit Signs Direction (continued)

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

Implemented (- 11/18/2024)

141b1 - Annual Medical Evaluation

7. Requirements

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

Description of Violation

As of , Resident #1 did not have a completed Document of Medical Evaluation since in the record.

Repeat Violation 5/14/2024.

Plan of Correction ***Accept - 11/06/2024)***

The Administrator and/or designee were re-educated on Regulation 2600.141.b.1. An audit of resident DME is currently being performed to ensure compliance with this regulation. Resident #1 has had an annual DME completed and added to the resident chart.
Completion Date: 10/3/2024
The Administrator and/or designee will continue to audit resident DME's monthly and upon new admission to continue compliance with this regulation. Results will be discussed during the QAPI review.

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

Implemented (- 11/18/2024)

183b - Meds and Syringes Locked

8. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

In Room 102 in the Anderson building, there was a small oval white pill found on the chair during the 10/3/2024 onsite inspection. There was no resident in the room. The medication was not administered correctly to the resident.

Plan of Correction ***Accept (- 11/06/2024)***

The Nursing Supervisor and Nursing staff were re-educated on the procedure of medication management and disbursement to maintain compliance with regulation 2600.183.b.
Completion Date: 10/31/2024
The Administrator and/or designee will audit resident medications daily and report as needed. Results will be discussed during the QAPI review.

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

Implemented (- 11/19/2024)

183e - Storing Medications

9. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #2 has an order for [redacted] give one drop by mouth every two hours as needed for cough. During [redacted] onsite inspection, it was discovered that Resident #2's [redacted] Drops had expired on [redacted].

Additionally, during 10/3/2024 onsite inspection, an audit of the first-floor medication cart, located in the Anderson Building, was conducted. An unidentified pink round pill was found loose in the second drawer of the medication cart.

Plan of Correction ***Accept ([redacted] - 11/06/2024)***

The Nursing Supervisor and/or designee were re-educated on this regulatory requirement. Daily audits are being conducted by nursing staff and/or designee to ensure maintained compliance with this regulation. The Nursing Supervisor and/or designee were re-educated on the storing of medications in the proper manner and keeping them organized and accounted for.
Completion Date: 10/9/2024
The Administrator and or Designee will observationally audit the medication carts weekly for 3 months to continue compliance or as needed thereafter. Results will be discussed during the QAPI review.

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

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 #6 has an order for [redacted], give one tablet by mouth four times a day for hypertension. During 10/3/2024 onsite inspection, it was discovered that on [redacted], the medication was only given 3 times and not given at [redacted].

Resident #7 has an order for [redacted], give one tablet by mouth two times a day for [redacted], hold if systolic blood pressure is less than [redacted] or heart rate is less than [redacted]. During [redacted] onsite inspection, it was discovered that the resident's blood pressure was [redacted] on [redacted]. The medication should have been held per prescriber's orders but was administered to the resident.

Plan of Correction ***Accept ([redacted] - 11/14/2024)***

The Nursing Supervisor and/or designee were re-educated on this regulatory requirement to ensure compliance with this regulation. Prescriber's orders will be followed and audited as needed for accuracy. Orders are monitored and

187d - Follow Prescriber's Orders (continued)

audited daily as they come in from the pharmacy and referenced to what the doctor has prescribed.
Completion Date: 10/9/2024
The Administrator and/or designee will audit the prescriber's orders daily and as needed. Results will be discussed during the QAPI review.

Licensee's Proposed Overall Completion Date: *11/13/2024*

Implemented (- 11/19/2024)

225a - Assessment 15 Days

11. 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

During 10/1/2024 onsite inspection, it was discovered that Resident #8, admitted to the home on , did not have the Resident Assessment and Support Plan completed until , exceeding the requirement of 15 days.

Repeat Violation 10/3/2023, et al.

Plan of Correction ***Accept (- 11/06/2024)***

No corrective action was indicated for the residents' record, as the RASP is completed. The Administrator and/or designee who participate in the completion of the initial admission assessment were re-educated regarding the regulatory requirement to ensure the written initial assessment is documented on the department's assessment form within 15 days of the admission.
Completion Date:10/1/2024
The Administrator and/or designee conduct audits to ensure written initial assessments are documented on the Department's assessment form within 15 days of admission monthly for 6 months and as needed thereafter. Results will be discussed during the QAPI review.

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

Implemented (- 11/18/2024)

227d - Support Plan Medical/Dental

12. 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

During 10/1/2024 onsite inspection, Resident #9 was identified as having impairment and utilizes a bed shaker to awaken the resident in the case of an emergency. The Resident Assessment and Support plan dated does not document the resident's need for a bed shaker to be alerted during an emergency while sleeping.

227d Support Plan Medical/Dental (continued)

Plan of Correction ***Accept [redacted] - 11/14/2024)***

The Administrator and licensed staff members who participate in documenting in the Resident Assessment and Support Plan we re educated regarding the regulatory requirement to ensure the documentation of the resident's needs are accurate and correct.
Completion Date: 10/1/2024
The Administrator and/or designee will audit new and existing resident records monthly for 3 months and as needed thereafter. Results will be discussed during the QAPI review.

Below is the information requested for 18. Compliance with Laws. I could not add any information as it was accepted.

18 Compliance with laws CO2 Detector log is attached along with picture of the Co2 detector that had a new battery installed with identifying tag with date.

131f Fire Extinguisher Inspection verification of monthly audits are on the fire extinguisher. Each Fire Extinguisher has a tag provided by Cintas. Our Maintenance Team Checks them off Monthly. The tags are used as the Log. Attached is a letter from Cintas stating the referenced above extinguishers were re inspected.

132e Fire Drill Sleeping Hours verification of trainings was attached along with training information.

85a Sanitary Conditions Attached is the Live Training Sign in sheet.

103i Outdated Food Training and Log Sheet

183b. Meds and Syringes Locked education and log sheet attached. Staff audit and do medication count at the end/start of every shift.

183e log sheet from 10/9/2024 ,storage and disposal of Medications

227d Date of Education was the day it was found, 10/1/2024. It was identified by the surveyor and was corrected that day.

225a Assessment 15 days Attached is the log in sheet for the re education on the initial written assessment.

141b1 Annual Medical Evaluation Education log sheet and audits attached.

Licensee's Proposed Overall Completion Date: *11/12/2024*

Implemented ([redacted] - 11/18/2024)