pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: APRIL 4, 2025

Ark Manor LLC
105 Sandra Drive
Delmont, PA 15626

RE: Ark Manor
105 Sandra Drive
Delmont, PA 15626
License/COC #: 446864

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 7, 2024, November 8, 2024, March 12, 2025, and March 17, 2025, of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REFUSES to RENEW your certificate of compliance (license number 44686) to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, gross incompetence, negligence and misconduct in operating the facility, and failure to submit an acceptable plan to correct noncompliance items and is made pursuant to 62 P.S. § 1026 (b)(1);(4) and 55 Pa. Code § 20.71(a)(2);(3);(4);(6) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

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.

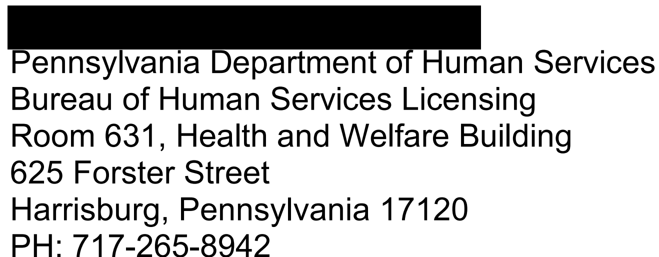
55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection X	Fine Per resident Per day	= Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
92	III	47	$3	$141	15 calendar days from mailing date of this letter
185(a)	II	47	$5	$235	5 calendar days from mailing date of this letter

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 <u>in writing</u> 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 REFUSE TO RENEW your 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision.

If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:


Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

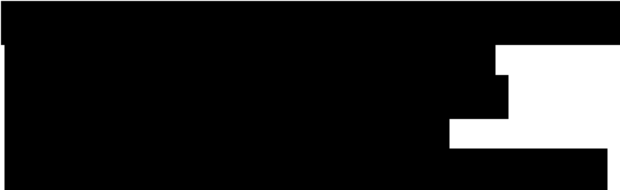
This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Country Manor is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: 

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

Facility Information

Name: *ARK MANOR* **License #**: *44686* **License Expiration**: *01/26/2025*

Address: *105 SANDRA DRIVE, DELMONT, PA 15626*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name:

Legal Entity

Name: *ARK MANOR LLC*

Address: *105 SANDRA DRIVE, DELMONT, PA, 15626*

Phone:

of Occupancy

Type: *C-2 LP* **Date**: *06/23/2006* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *40* **Waking Staff**: *30*

Inspection Information

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

Reason: *Renewal, Complaint, Fine, Monitoring* **Exit Conference Date**: *11/22/2024*

Inspection Dates and Department Representative

11/07/2024 - On-Site:

11/08/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served**: *40*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *17* **Are 60 Years of Age or Older**: *13*

Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability**: *2*

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

Inspections / Reviews

11/07/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/06/2025*

02/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/16/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/06/2025*

02/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/06/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/20/2025*

03/21/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On 11/7/24 at 10:57 a.m. there were no paper towels, mechanical air blower, individual cloth towels or other sanitary means of hand drying in the shared bathroom of bedroom #101 and bedroom #103.

Plan of Correction ***Accept █ - 02/02/2025)***

On 01/15/2025 administrator did a check of all bathrooms in the facility to ensure paper towels were available in each. All DCS will be re trained on 2600.85.a, no later than 01/31/2025 by administrator. Documentation of re education will be kept. Beginning 01/20/2025 administrator or designated staff will check all bathrooms in the facility to ensure paper towels are readily available. check will be conducted twice per week. Documentation will be kept x 4 weeks,

Licensee's Proposed Overall Completion Date: *01/16/2025*

Not Implemented█ - 03/21/2025)

3. Requirements

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

Description of Violation

On 11/7/24 at 10:00 a.m. there were approximately 1 dozen clumps of what appeared to be feces and a dead bug approximately the size of a quarter on the right shower floor of the common bathroom across the hall from the administrator's office.

On 11/7/24 at 10:05 a.m. the ventilation fan was completely covered with lint in the common bathroom across the hall from the administrator's office.

On 11/7/24 at 10:23 a.m. the shared bathroom for resident #2 and resident #3 had an offensive odor so pungent it evoked a nonvoluntary gag response.

On 11/7/24 at 11:20 a.m. there was what appeared to be dried feces on the inside rim of the shower chair in the Blue Hall common bathroom shower.

Plan of Correction ***Accept █ - 02/02/2025)***

on 11/7/24 when inspectors were on site wing 4 shower room was cleaned by housekeeping, shared bathroom between resident #2 and 3 was cleaned by housekeeping as well as the blue hall shower room.
All DCS will be re trained on 2600.85.a, no later than 01/31/2025 by administrator. Documentation of re education will be kept.
Beginning 01/20/2025 administrator or designated staff will check all areas in the facility to ensure sanitary conditions are being maintained. check will be conducted minimally of once per shift. Documentation will be kept x 4 weeks,

85a - Sanitary Conditions *(continued)*

Licensee's Proposed Overall Completion Date: *01/16/2025*

Not Implemented - 03/21/2025)

85b - Infestation

5. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 11/7/24 at 10:25 a.m. there were numerous dead gnats on resident #2's bedside dresser.

On 11/7/24 at 10:46 a.m. there were numerous spiders and various other flying insects in the basement.

Plan of Correction ***Accept - 02/02/2025)***

On 11/7/2024, when inspectors were on site, resident #2's bedroom was deep cleaned, including the gnats on bedside dresser.
On 11/11/2024 maintenance cleaned basement area.
All DCS will be re trained on 2600.85.a, no later than 01/31/2025 by administrator. Documentation of re education will be kept.
Beginning 01/20/2025 administrator or designated staff will check all areas in the facility to ensure sanitary conditions are being maintained. check will be conducted minimally of once per shift. Documentation will be kept x 4 weeks,

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented - 03/21/2025)

85d - Trash Receptacles

6. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 11/7/24 at 10:50 a.m. there was a overflowing, uncovered, unattended trash can in the common bathroom at the end of Green Hall.

Repeat Violation: 1/4/2024 et al

Plan of Correction ***Directed (- 02/13/2025)***

On 11/09/2024 the administrator placed a trash can containing a lid was put in the green hall staff bath room.
On 01/15/2025 administrator did a check of all bathrooms and kitchen areas in the home to ensure all trash cans were covered trash receptacles.
All DCS will be re trained on 2600.85.da, no later than 01/31/2025 by administrator. Documentation of re education will be kept.
Beginning 01/20/2025 administrator or designated staff will check all bathrooms and kitchen areas to ensure compliance with 2600.85.d.

85d - Trash Receptacles (continued)

check will be conducted twice per week. Documentation will be kept x 4 weeks,

Proposed Overall Completion Date: 02/06/2025

Directed:
By 2/20/25 and twice weekly thereafter, the administrator or designee will monitor the home to ensure trash in kitchens and bathrooms are kept in covered trash receptacles that prevent the penetration of insects and rodents. Documentation will be kept.
SQ 2/13/25

Directed Completion Date: *02/20/2025*

Implemented - 03/21/2025)

86b - Bathroom

7. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 11/7/24 at 11:14 a.m. the shared bathroom of bedroom #101 and bedroom #103 did not have an operable window or ventilation fan. The ventilation fan was inoperable and there is no window in the bathroom.

Plan of Correction ***Accept - 02/13/2025)***

On 11-11-2024 maintenance was notified that vent in shared bathroom between 101 and 103 in need of repaired.
All staff will be re trained on 2600.86.b no later than 01/31/2025.
Administrator will conduct check of all bathroom vents by 01/24/2025 monthly checks will be done by admin or designee beginning 2/10/2025.
Any inoperable vents, including vent in shared bathroom between 101 and 103, will be repaired no later than 01/31/2025

Proposed Overall Completion Date: 02/06/2025

Licensee's Proposed Overall Completion Date: *02/06/2025*

Implemented - 03/21/2025)

88a - Surfaces

8. 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

On 11/7/24 at 10:03 a.m. there was an approximate 6" x 8" section of floor tile missing from the left side of the common bathroom across the hall from the administrator's office.

88a - Surfaces (continued)

On 11/7/24 at 10:04 a.m. there was an approximate 3' x 6" area of damaged plaster on the wall underneath the sink and behind the toilet in the common bathroom across the hall from the administrator's office.

Plan of Correction ***Directed █ - 02/13/2025)***

All staff will be retrained on 2600.88.a no later than 01/31/2025 by Administrator. documentation of retraining will be kept.
administrator will conduct a complete walk through of the home, checking all floors, walls, ceilings, windows, doors and other surfaces ensuring all clean, in good repair and free of hazard no later than 01/24/2025. monthly checks there after will be conducted by admin or designee to begin 02/10/2025, documentation will be kept.
All necessary repairs, including the tile in wing 4 shower room and the area below sink in wing 4 shower room will be repaired by maintenance 01/31/2025.

Proposed Overall Completion Date: 02/06/2025

Directed:
By 2/20/25 and daily thereafter, the administrator or designee will monitor the home to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Documentation will be kept.
SQ 2/13/25

Directed Completion Date: *02/20/2025*

Not Implemented █ - 03/21/2025)

10. 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

On 11/7/24 at 10:16 a.m. the bottom right door hinge on the double doors between the common area and rear porch was rusted and in disrepair, causing an approximate 1" separation between the hinge and the door jamb.

On 11/7/24 at 10:21 a.m. there was no doorknob on the on the study room door.

On 11/7/24 at 11:26 a.m., there was no doorknob on the exterior side of the Wing 1 exit door.

Plan of Correction ***Directed █ - 02/13/2025)***

All staff will be retrained on 2600.88.a no later than 01/31/2025. documentation of retraining will be kept.
administrator will conduct a complete walk through of the home, checking all floors, walls, ceilings, windows, doors and other surfaces ensuring all clean, in good repair and free of hazard no later than 01/24/2025. monthly checks to begin 2/10/25 by admin or designee, documentation will be kept.
All necessary repairs, including door between common area and rear porch, door knob to study room and doorknob on the exterior side of wing 1 exit door will be repaired by 01/31/2025 by maintenance.

Proposed Overall Completion Date: 02/06/2025

Directed:

88a - Surfaces (continued)

By 2/20/25 and daily thereafter, the administrator or designee will monitor the home to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Documentation will be kept.

SQ 2/13/25

Directed Completion Date: *02/20/2025*

Not Implemented ███ - 03/21/2025)

89a - Water Pressure

11. 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 11/7/24 at 10:00a.m. the home did not have sufficient hot water pressure to the bathroom sink in the common bathroom across from the administrator's office.

Plan of Correction ***Accept ███ - 02/13/2025)***

All staff will be retrained on 2600.89.a no later than 01/31/2025 by Administrator
documentation of retraining will be kept.
administrator will conduct a complete walk through of the home, checking all water to ensure compliance with 2600.89.a no later than 01/24/2025. weekly checks by admin or designee to begin 2/10/25, documentation will be kept.
All necessary repairs, including the insufficient hot water pressure to bathroom sink in the wing 4 shower room, will be repaired by 01/31/2025 by maintenance.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Implemented ███ - 03/21/2025)

92 - Windows

12. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 11/7/24 at 10:25 a.m. there was no screen in the left-side window of bedroom #409.

On 11/7/24 at 10:37 a.m. the screen was torn out and hanging from the door of the freezer utility room.

On 11/7/24 at 11:12 a.m. the shower room screen in the Red Hall common bathroom was ajar, creating an approximate 2" gap.

On 11/7/24 at 11:16 a.m. there was no screen in the right-side window of bedroom #303.

92 - Windows (continued)

On 11/7/24 at 11:17 a.m. there was no screen in the right-side window of bedroom #301.

On 11/7/24 at 11:21 a.m. there was no screen in the laundry room window.

Repeat Violation: 1/4/2024 et al

Plan of Correction ***Accept - 02/13/2025)***

All staff will be retrained on 2600.92 no later than 01/31/2025 by administrator
documentation of retraining will be kept.
administrator will conduct a complete walk through to ensure windows are in good repair and securely screened to ensure compliance no later than 01/24/2025. weekly checks by admin or designee to begin 2/10/25, documentation will be kept.
All necessary repairs, including window in bedroom 409- utility door window- red hall shower room- bedroom 303- bedroom 301 and laundry room window, will be repaired by 01/31/2025.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Not Implemented - 03/21/2025)

95 - Furniture and Equipment

13. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 11/7/24 at 10:03 a.m. there was no shower head in the left shower of the common bathroom across the hall from the administrator's office, producing a forceful jet of water from the shower opening when the water was turned on.

On 11/7/24 at 10:04 a.m. the lights in both shower rooms were inoperable in the common bathroom across the hall from the Administrator's office.

Plan of Correction ***Accept - 02/13/2025)***

All staff will be retrained on 2600.95 no later than 01/31/2025 by administrator.
documentation of retraining will be kept.
administrator will conduct a complete walk through of the home, checking ensuring all furniture and equipment is in good repair, clean and free of hazard no later than 01/24/2025. Monthly checks by admin or designee to begin 2/10/25, documentation will be kept.
All necessary repairs, including the wing 4 shower room shower head and bathroom lights, will be repaired by 01/31/2025 by maintenance.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Not Implemented - 03/21/2025)

100a - Exterior - Free of Hazards

14. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

100a - Exterior - Free of Hazards *(continued)*

Description of Violation

On 11/7/24 at 11:07 a.m. the rear patio deck was in disrepair, posing multiple trip/fall hazards as follows:
• An approximate 12' long x 18" wide section of deck planks at the edge of the deck was missing, exposing multiple floor joists.
• An approximate 14' long x 8" wide section of deck planks at the edge of the deck was missing, exposing multiple floor joists.

Repeat Violation: 1/4/2024 et al

Plan of Correction ***Accept (- 02/13/2025)***

All staff will be retrained on 2600.100.a no later than 01/31/2025 by administrator
documentation of retraining will be kept.
administrator will conduct a complete walk through of the home the exterior of the building and the building grounds to ensure compliance with 2600.100.a, no later than 01/24/2025. weekly checks by admin or designee to begin 2/10/25, documentation will be kept.
All necessary repairs to deck have been made on 12/23/24 by maintenance
Any other repairs found during administrators walk through of exterior grounds will be be repaired by 01/31/2025.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Implemented (- 03/21/2025)

101j3 - Bed/Linens/Pillows/Blankets

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 11/7/24 at 11:14 a.m. there was what appeared to be dried feces on the fitted sheet of resident #4's bed.

Plan of Correction ***Accept - 02/13/2025)***

Resident #4's bed was made clean on 11/07/2024 when inspectors were on site by housekeeping.
All staff will be retrained on 2600.101.j no later than 01/31/2025 by administrator.
documentation of retraining will be kept.
After retraining is complete- DCS will complete daily checks to ensure each resident has pillow, bed linens and blanket that are clean and in good repair. Documentation of DCS checks will be kept.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Not Implemented - 03/21/2025)

101j7 - Lighting/Operable Lamp

16. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 11/7/24 at 11:01 a.m. resident #1 did not have access to a source of light that can be turned on/off at bedside.

101j7 - Lighting/Operable Lamp (continued)

On 11/7/24 at 11:16 a.m. resident #5 did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Directed - 02/13/2025)***

On 11/09/2024 a operable light source was put at bed side for resident #1 and resident #5 by administrator.
On 01/15/2025 administrator did a check of all resident bedrooms to ensure operable lamp or other light source that can be turned on at bedside.
All DCS will be re trained on 2600.101.j, no later than 01/31/2025 by administrator. Documentation of re education will be kept.
Beginning 01/20/2025 administrator or designated staff will check all rewident's bedside light source to ensure compliance with 2600.101.j.
check will be conducted twice per week. Documentation will be kept x 4 weeks,

Proposed Overall Completion Date: 02/06/2025

Directed:
By 2/20/25 and twice per week thereafter, the administrator or designee will check all resident bedrooms to ensure each resident has an operable lamp or other source of lighting that can be turned on at bedside. Documentation will be kept.
2/13/25

Directed Completion Date: *02/20/2025*

Implemented - 03/21/2025)

103d - Storing Food Off Floor

17. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 11/7/24 at 9:10a.m. two boxes containing four 1-gallon jugs of the home's emergency water supply was stored on the floor in the corner of office room #412.

Plan of Correction ***Accept - 02/13/2025)***

On 11/09/2024 the boxes containing emergency water was moved to store off the floor by .
All staff will be retrained on 2600.103.d by administrator no later than 01/31/2025. documentation of retraining will be kept.
Beginning 01/20/2025 administrator, or designated staff, will check all areas food and/or water are stored, minimally of weekly, to ensure compliance with 2600.103.d. documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Implemented - 03/21/2025)

103f - Refrigerator/Freezer Temps

18. Requirements

2600.

103f - Refrigerator/Freezer Temps *(continued)*

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 11/7/24 there was no thermometer in the main kitchen's double door refrigerator. The refrigerator had an exterior thermometer; however, it was not operational.

Repeat Violation: 1/4/2024 et al

Plan of Correction ***Accept - 02/13/2025)***

an operable thermometer was placed in the kitchen's side by side fridge on 11/09/2024 by administrator.
All staff will be retrained on 2600.103.f no later than 01/31/2025.
Beginning 02/10/2025, kitchen staff will check daily to ensure thermometers are in each fridge and freezer, documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Not Implemented - 03/21/2025)

103g - Storing Food

19. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 11/7/24 at 10:32 a.m. there was an uncovered and freezer burned sausage link and multiple uncovered French fries on the floor of the freezer.

Plan of Correction ***Accept - 02/13/2025)***

on 11/09/2024 the sausage and french fries were cleaned off freezer floor by kitchen staff.
All staff will be re educated on 2600.103.g no later than 01/31/2025, documentation of re education will be kept.
Beginning 01/19/2025 administrator or dietary staff will do twice weekly checks to ensure compliance with 2600.103.g

Licensee's Proposed Overall Completion Date: *02/06/2025*

Not Implemented - 03/21/2025)

107c - Food/Water 3 Day Supply

20. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 11/7/24, the home served 40 residents, requiring 120 gallons of emergency drinking water. However, the home had only 20 gallons. The home does not have a contractual agreement with a vendor indicating how much water will be delivered, a guarantee that the water will be delivered immediately upon request, 24-hours-per-day, and a guarantee that the water will be delivered as a priority even in the event of a regional general emergency.

Plan of Correction ***Directed - 02/13/2025)***

A one day supply of emergency water is in the home.
On 12/12/2024, administrator contacted walmart in Delmont, PA confirming that in the event of an emergency

107c - Food/Water 3 Day Supply (continued)

there is guaranteed over the amount of needed drinking water available for purchase. Administrator also contacting food service provider to get contract agreement for water supply. Contract or necessary water will be on site no later than 02/14/2025

Proposed Overall Completion Date: 02/06/2025

Directed:
By 2/20/25 and weekly thereafter, the administrator will audit the home's emergency water supply to ensure that home has and maintains at least 1 gallon of water per day per resident for 3 days. Documentation will be kept.
SQ 2/13/25

Directed Completion Date: *02/20/2025*

Implemented ██ - 03/21/2025)

121a - Unobstructed Egress

21. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 11/7/24 at approximately 10:41 a.m. the left-side emergency exit door across the hall from the main dining room required significant force to be opened.

On 11/7/2 at approximately 11:10 a.m. the emergency exit door leading from the large common living room to the rear exterior deck required significant force to be opened.

Repeat Violation: 5/9/2024

Plan of Correction ***Accept ██ 02/13/2025)***

All staff will be retrained on 2600.121.a no later than 01/31/2025 by administrator. documentation of retraining will be kept.
Administrator will do complete walk through of the facility, checking all hallways, doorways, passageways and egress routes from rooms and the building to ensure compliance with 2600.121.a no later than 01/24/2025.
Necessary repairs, including exit door exiting dining room and exit door leading to back patio, to be completed by 01/31/2025.
daily checks by admin or designee to begin 2/10/25, documentation will be kept.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Not Implemented ██ - 03/21/2025)

123c - Evacuation Diagrams

22. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

123c - Evacuation Diagrams *(continued)*

Description of Violation

The home currently serves 40 residents. However, the emergency evacuation diagrams posted do not include the line of travel to exit doors.

Plan of Correction ***Directed ██ - 02/13/2025)***

Dispute: All emergency evacuation exit diagrams show line of travel to the exit doors, these diagrams are posted in the building and no change was required to be in compliance with 2600.123.c

Proposed Overall Completion Date: 02/06/2025

Directed:

By 2/20/25, the administrator or designee will update all emergency evacuation diagrams to indicate the line of travel to exit doors for all areas of the building, to include wing 1, wing 3, wing 4 and the common area.

██ ***2/13/25***

Directed:

By 2/20/25 and monthly thereafter, the administrator or designee will monitor the home to ensure an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals is posted in a conspicuous and public place on each floor. Documentation will be kept.

██ ***2/13/25***

Directed Completion Date: *02/06/2025*

Not Implemented ██ - 03/21/2025)

132e - Fire Drill Sleeping Hours

23. Requirements

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

Description of Violation

The last fire drill conducted during sleeping hours was on 4/21/24 at 3:09 a.m.

Plan of Correction ***Accept ██ - 02/03/2025)***

On 11/12/2024 at 5:10am was held during sleeping hours. Administrator has produced a reminder for May of 2025 and November 2025. Administrator will continue with every 6 months reminders to ensure drills are conducted promptly on time and continued compliance being maintained.

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented ██ - 03/21/2025)

183e - Storing Medications

24. Requirements

2600.

183e - Storing Medications *(continued)*

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 #3’s Novolog FlexPen was not labeled with the date it was opened. The manufacturer's instructions indicate the medication expires 28 days after opening.

Resident #6’s Insulin Lispro was not labeled with the date it was opened. The manufacturer's instructions indicate the medication expires 28 days after opening.

Resident #7’s Lantus Solostar was not labeled with the date it was opened. The manufacturer's instructions indicate the medication expires 28 days after opening.

Resident #8’s Insulin Lispro was not labeled with the date it was opened. The manufacturer's instructions indicate the medication expires 28 days after opening.

Repeat violation: 5/9/2024, 10/13/2023

Plan of Correction ***Accept [redacted] - 02/13/2025)***

Administrator conducted check 11/08/2024 to ensure all insulin pens were dated.
All DHS med techs will be re educated on 2600.183.e by administrator no later than 01/31/2025.
DHS med tech, [redacted] began audits of all opened insulin pens on 11/22/2024 to ensure dated and in compliance with 2600.183.e. monitoring 3 times per week. Administrator also doing weekly audit 11/22/24 to ensure compliance. Documentation of audits being kept.

Licensee's Proposed Overall Completion Date: *02/06/2025*

Implemented [redacted] - 03/21/2025)

185a - Implement Storage Procedures

25. 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.

Description of Violation

On 10/24/24 at 11:37 a.m. resident #4's blood glucose level was 271; however, the resident's October 2024 medication administration record (MAR) indicates the resident's blood glucose level was 211.

On 10/30/24 at 11:59 a.m. resident #4's blood glucose level was 138; however, the resident's October 2024 MAR indicates the resident's blood glucose level was 278.

Resident #4’s glucometer was not set to the correct date or time.

On 11/6/24 at 5:00 p.m. resident #6's blood glucose level was 138; however, the resident's November 2024 MAR indicates the resident's blood glucose level was 278.

On 11/6/24 at 5:00 pm. resident #6’s November 2024 MAR indicated a blood glucose reading of 165; however, this

185a - Implement Storage Procedures (continued)

reading was not on the resident’s glucometer.

On 11/7/24 at 9:31 a.m. resident #7's blood glucose level was 282; however, the resident's November 2024 MAR indicates the resident's blood glucose level was 165.

On 11/2/24 at 9:04 a.m. resident #9's blood glucose level was 173; however, the resident's November 2024 MAR indicates the resident's blood glucose level was 273.

Repeat Violation: 1/4/2024 et al, 10/13/2023

Plan of Correction ***Directed █ - 02/13/2025)***

All DHS med techs will be re educated on 2600.185.a by administrator no later than 01/31/2025. Documentation of re training will be kept.
Beginning in December of 2024, all residents have a full med audit, to include glucose reading checks to confirm all entries are accurate. Audits will be done weekly minimally of 3 additional months by DHS med techs.

Proposed Overall Completion Date: 02/06/2025

Directed:
By 2/20/25 and weekly thereafter, the administrator or designee will audit glucometer readings for all residents, to include comparing the reading on the resident's glucometer to the reading documented on the resident MAR. Documentation will be kept.
█ ***2/13/25***

Directed Completion Date: *02/20/2025*

Not Implemented █ - 03/21/2025)

26. 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.

Description of Violation

The home’s Accountability of Medication and Controlled Substances indicates; “All narcotics will be kept double locked in the medication cart and will be counted at the beginning and end of each shift."

Resident #9 is prescribed Lorazepam, 2mg/ml syringes, give 0.5ml every 2 hours as needed. Resident #9’s Individual Narcotic Sheet indicates there should be 12 doses remaining. However, there were only 11 doses present in the home, and the home was unable to account for the missing medication.

Resident #9 is prescribed Morphine sulphate 20mg/ml, give 0.5ml by mouth every hour as needed. Resident #9’s Individual Narcotic Sheet indicates there should be 13 doses remaining. However, there were only 12 doses present in the home, and the home was unable to account for the missing medication.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (█ - 02/03/2025)***

All DHS med techs will be re educated on 2600.185.a by administrator no later than 01/31/2025. Documentation of re training will be kept. Upon re education med techs will review Narc count procedure. Beginning 01/19/2025, administrator will check each scheduled day to ensure all narc counts are being completed at the beginning and end of each shift. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *01/16/2025*

Not Implemented █ - 03/21/2025)

187b - Date/Time of Medication Admin.

27. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed Tramadol HCL 50mg tablet, take 1 tablet three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. Staff person A, staff person B and staff person C signed resident #4's November 2024 MAR indicating the mediation was administered on the following dates and times; however, the medication was not administered because it was not available in the home:

Date:	*Time:*	*Staff Person:*
11/6/24	*2:00 p.m.*	*A*
11/6/24	*8:00 p.m.*	*B*
11/7/24	*8:00 a.m.*	*C*
11/7/24	*2:00 p.m.*	*C*
11/7/24	*8:00 p.m.*	*B*

Repeat Violation: 5/9/2024

Plan of Correction ***Directed █ - 02/13/2025)***

Resident #4 was opened with hospice upon inspection, hospice was notified of needed refill when inspectors were on site and medication was reordered and delivered.
All DHS med techs will be retrained on 2600.187.b no later than 01/31/2025 by administrator beginning 02/01/2024 Scheduled med tech will be responsible to ensure all needed refills are addressed with provider prior to their shift's end each shift. Administrator will conduct checks, minimally of weekly to ensure compliance.

Proposed Overall Completion Date: 02/06/2025

Directed:
Beginning 2/20/25, documentation of all checks as indicated above will be kept.
█ ***2/13/25***

Directed Completion Date: *02/20/2025*

Implemented █ - 03/21/2025)

187c - Refusal of Medication

28. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #9 is prescribed Humalog 100 units/ML Kwikpen, check blood sugar before meals and at bedtime. Administer insulin per sliding scale:

0-150 = 0 units

151-200 = 2 units

201-250 = 4 units

251-300 = 6 units

301-350 = 8 units

351-400 = 10 unit

Over 400= 10 units and call DR.

Resident #9 refused the administration of this medication on 10/8/24 at 7:00 a.m., and 10/16/24, at 8:00 p.m. However, the prescribing physician was not notified.

Plan of Correction ***Accept[redacted] - 02/03/2025)***

DHS med techs will be re trained by administrator on 2600.187.c no later than 01/31/2025, documentation of re training will be kept. med tech retraining will include proper steps of notifying prescriber and proper documentation in the resident's record and on the medication record. Beginning 01/19/2025, administrator will review MARs and ensure refusals are documented and reported per regulation. admin reviews to be done minimally of weekly and documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented [redacted] - 03/21/2025)

187d - Follow Prescriber's Orders

29. Requirements

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

Description of Violation

Resident #4 is prescribed Tramadol HCL 50mg tablet, take 1 tablet three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m. Resident # 4 was not administered this medication on the following dates and times because it was not available in the home:

Date:	*Time:*
11/6/24	*2:00 p.m.*
11/6/24	*8:00 p.m.*
11/7/24	*8:00 a.m.*
11/7/24	*2:00 p.m.*
11/7/24	*8:00 p.m.*

187d - Follow Prescriber's Orders (continued)

Repeat Violation: 5/9/24

Plan of Correction ***Directed █ - 02/13/2025)***

Resident #4 was opened with hospice upon inspection, hospice was notified of needed refill when inspectors were on site and medication was reordered and delivered.
All DHS med techs will be retrained on 2600.187.d no later than 01/31/2025 by administrator
starting 02/01/205 Scheduled med tech will be responsible to ensure all needed refills are addressed with provider prior to their shift's end each shift. Administrator will conduct checks, minimally of weekly begin 02/1/25 to ensure compliance.

Proposed Overall Completion Date: 02/06/2025

Directed:
Beginning 2/20/25 and prior to the end of each shift thereafter, the scheduled med tech will conduct checks as indicated above and documentation will be kept.
█ ***2/13/25***

Directed Completion Date: *02/06/2025*

Not Implemented █ - 03/21/2025)

30. Requirements

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

Description of Violation

Resident #4 is prescribed Insulin Aspart 100 unit/ml, inject before meals and at bedtime per sliding scale:
151-180 = 2 units
181-200 = 4 units
201-250 = 6 units
251-300 = 8 units
301-350 = 10 units
351-400 = 12 units
> 400 call MD.
On 11/2/24 at 5:00 p.m. resident #4's blood sugar reading was 142 and the resident was administered 4 units of Insulin. However, according to the prescriber's orders, no Novolog should have been administered.

On 11/7/24 at 12:00 p.m. resident #4's blood sugar reading was 251 and the resident was administered 7 units of Novolog. However, according to the prescriber's orders, 8 units should have been administered.

Resident #9 is prescribed Humalog 100 units/ML Kwikpen, check blood sugar before meals and at bedtime.

187d - Follow Prescriber's Orders (continued)

Administer insulin per sliding scale:
0-150 = 0 units
151-200 = 2 units
201-250 = 4 units
251-300 = 6 units
301-350 = 8 units
351-400 = 10 unit
Over 400= 10 units and call DR.
On 10/1/24 at 7:00 a.m. resident 9's blood sugar reading was 141 and the resident was administered 2 units of Humalog. However, according to the prescriber's orders, no Humalog should have been administered.

Plan of Correction *Repeat Violation: 5/9/2024* ***Directed (- 02/13/2025)***

All DHS med techs will be re educated on 2600.187.d by administrator no later than 01/31/2025. Documentation of re training will be kept.
Beginning in December of 2024, all residents have a full med audit, to include glucose reading checks to confirm all entries are accurate. Audits will be done by DHS med techs weekly minimally of 3 additional months.

Proposed Overall Completion Date: 02/06/2025

Directed:
Beginning 2/20/25 and weekly thereafter, the administrator or designee will conduct full medication audits for all residents, to include glucose reading checks to confirm all entries in the resident MAR are accurate. Documentation of all audits will be kept.
2/13/25

Directed Completion Date: *02/20/2025*

Not Implemented - 03/21/2025)

254a - Records Discharge/Active

31. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 11/7/24, boxes of records for numerous former residents including residents #10 and #11, were unlocked, unattended, and accessible in office room #412.

Plan of Correction ***Accept (SQ - 02/03/2025)***

On 11/8/2025 administrator posted on office #412 that the door must remain locked and check each day is in the home to ensure room 412 is remaining locked.
All staff will be re educated on 2600.254.a to ensure compliance. re training to be completed by the administrator no later than 01/31/2025. Documentation of re training will be kept.

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented - 03/21/2025)