pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SUGAR VALLEY LODGE INC**
LEGAL ENTITY

To operate **SUGAR VALLEY LODGE (WHISPERING PINES BUILDING)**
NAME OF FACILITY OR AGENCY

Located at **178 SUGAR VALLEY LANE, FRANKLIN, PA 16323**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **15**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **January 31, 2025** until **July 31, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **447721**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 31, 2025

[REDACTED], Board President
Sugar Valley Lodge Inc.
[REDACTED]
[REDACTED]

RE: Sugar Valley Lodge (Whispering Pines Building)
178 Sugar Valley Lane
Franklin, PA 16323
License/COC #: 447721

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 6, 2024 and November 19, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 44772) dated August 10, 2024 to August 10, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from January 31, 2025 to July 31, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL 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. If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

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.

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: *SUGAR VALLEY LODGE (WHISPERING PINES BUILDING)* **License #**: *44772* **License Expiration**: *08/10/2024*

Address: *178 SUGAR VALLEY LANE, FRANKLIN, PA 16323*

County: *VENANGO* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *SUGAR VALLEY LODGE INC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/20/2016* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *06/12/2024*

Inspection Dates and Department Representative

06/06/2024 - On-Site:
06/10/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *15* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *8*
Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *3*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

06/06/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/12/2024*

07/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/07/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/30/2024*

09/24/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/07/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/15/2024*

01/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/07/2024*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 6/6/24, the home's most recent renewal licensing inspection summary, dated 5/9/23 and summaries after, including 6/26/23 and 8/10/23 were not posted in a conspicuous and public place in the home.

Repeat violation: 5/9/23 et al

Plan of Correction ***Accept (- 09/04/2024)***

On 6/10/2024 CEO posted the recent renewal licensing inspection summaries in the living area of whispering pines.
On 6/13/2024 CEO gave verbal education to the other administration about posting their most recent renewal licensing inspection summaries in a conspicuous and public place in the home.
Starting 8/1/2024 CEO will check quarterly to ensure that the recent licensing renewal is still posting in the living areas of the home.

Licensee's Proposed Overall Completion Date: *08/05/2024*

NOT IMPLEMENTED 1/3/25

15a - Resident Abuse Report

2. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 6/5/24, at approximately 12:00 pm., while residents #1 and #2 were taking their dirty plates to the front of the dining area after eating, the two residents started arguing. Resident #1 hip bumped resident #2. Staff person A intervened by telling residents "Let's not do this today". The residents continued to name call, when resident #1 punched resident #2 on the upper arm. Resident #2 left the dining area as staff told the residents "Stop the behavior" and attempted to divide residents #1 and #2. Resident #1 hip bumped staff person A as resident #1 attempted to get at resident #2. The local police were called but did not show up. No injuries occurred. However, this allegation of abuse was not reported to the local Area Agency on Aging until 6/10/24.

Plan of Correction ***Accept (- 09/04/2024)***

On 6/10/2024 CEO reported the abuse to the local Area Agency on Aging.
on 6/29/2024 trainer with milestone pa organization gave training and education to staff on how and who to report abuse to.
Stating on 6/29/2024 CEO will have annual training done from outside trainers on how and who to report abuse to.

Licensee's Proposed Overall Completion Date: *08/05/2024*

Implemented (- 01/03/2025)

16c - Written Incident Report

3. 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 6/5/24, at approximately 12:00 pm., while residents #1 and #2 were taking their dirty plates to the front of the dining area after eating, the two residents started arguing. Resident #1 hip bumped resident #2. Staff person A intervened by telling residents "Let's not do this today". The residents continued to name call, when resident #1 punched resident #2 on the upper arm. Resident #2 left the dining area as staff told the residents "Stop the behavior" and attempted to divide residents #1 and #2. Resident #1 hip bumped staff person A as resident #1 attempted to get at resident #2. The local police were called but did not show up. No injuries occurred. However, the home did not report this incident to the Department until 6/10/24.

Plan of Correction ***Accept (- 09/04/2024)***

On 6/10/2024 CEO reported the abuse to the Department's personal care home regional office.
on 6/29/2024 trainer with milestone pa organization gave training and education to staff on how and who to report abuse to.
Stating on 6/29/2024 CEO will have annual training done from outside trainers on how and who to report abuse to.

Licensee's Proposed Overall Completion Date: *08/05/2024*

Implemented (- 01/03/2025)

25c7 - Financial Assistance

4. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
7. The financial arrangements if assistance with financial management is to be provided.

Description of Violation

The resident-home contract, dated , for resident #2 and resident-home contract, dated , for resident #3 who receives assistance with financial management from the home, does not specify the arrangements under which this assistance will be provided.

Plan of Correction ***Accept (- 09/04/2024)***

On 6/13/2024 CEO update resident #2 and resident #3 contract to state what their financial management from the home entailed.
On 6/13/2024 CEO gave verbal education to the other administrators on checking the other contracts and ensuring that they were done correctly.
Starting on 7/1/2024 CEO will ensure that all contracts moving forward state what the financial management from the home entails. As well as auditing all the contracts quarterly.

Licensee's Proposed Overall Completion Date: *08/05/2024*

Implemented (- 01/03/2025)

25b SOPb2 - Rent Rebate: Intended Use

5. Requirements

2600.
25b.b.2. If the home collects a resident's rent rebate under subsection (a), the resident-home contract is to include the following: The home's intended use of the revenue collected from the rent rebate.

Description of Violation

The home collects a portion of the rent rebate benefit for eligible residents. Multiple residents, including residents #2 and #3 are eligible residents. The resident-home contract dated [redacted], for resident #2 and the resident-home contract dated [redacted], for resident #3 do not include the home's intended use for rent rebate revenues collected.

Plan of Correction ***Accept ([redacted] - 09/04/2024)***

On 6/10/2024 [redacted] CEO made an addendum to the home contract stating that the home takes 50% of the rent rebate and what it is used for.
On 6/12/2024 [redacted] CEO had all the residents sign the addendum and updated the contracts.
Starting on 7/1/2024 [redacted] CEO will ensure that all contracts present, and future have the addendum in the contract. As well as auditing the contracts on a quarterly basis.

Licensee's Proposed Overall Completion Date: *08/05/2024*

NOT IMPLEMENTED 1/3/25 [redacted]

26a - Quality Management Plan

6. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not do a quality management plan for 2023.

Plan of Correction ***Directed ([redacted] - 09/04/2024)***

On 6/13/2024 [redacted] COO devised a quality management plan for the year to start on 7/1/2024.
On 7/1/2024 [redacted] COO had his first quality management with the quality management team.
Starting on 7/1/2024 [redacted] COO will hold monthly quality management meetings with the quality management team.

Proposed Overall Completion Date: 08/05/2024

By 10/10/24: The administrator or designee shall develop and implement a tracking system to ensure a quality management meeting is conducted at least once every 12 months. Documentation of the tracking system shall be kept.

Directed Completion Date: *10/10/2024*

Implemented ([redacted] - 01/03/2025)

65a - FS Orientation 1st Day

7. Requirements

2600.

65a - FS Orientation 1st Day *(continued)*

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:

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.

Description of Violation

Staff person D, whose first day of work was [redacted] did not receive any orientation in general fire safety and emergency preparedness.

Plan of Correction ***Directed ([redacted] - 09/04/2024)***

On 6/10/2024 [redacted] COO went over the general fire safety and emergency plan with staff person D.
On 6/13/2024 [redacted] COO created a spreadsheet for all new hires to ensure that they get the proper orientation upon hire.
Starting on 6/14/2024 [redacted] COO will ensure that all new hires get the proper orientation by using the spreadsheet created.

Proposed Overall Completion Date: 08/06/2024

By 10/10/24: The administrator or designee shall audit all current staff records to ensure all staff persons have received an orientation training in general fire safety and emergency preparedness. Documentation of the audit shall be kept.

Directed Completion Date: *10/10/2024*

NOT IMPLEMENTED 1/3/25 [redacted]

65b - Rights/Abuse 40 Hours

8. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person D completed [redacted] 40th scheduled work hour. However, this staff person did not complete any of the required training.

Plan of Correction ***Accept ([redacted] - 09/24/2024)***

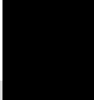
On 6/10/2024 [redacted] COO went over the general fire safety and emergency plan with staff person D.
On 6/13/2024 [redacted] COO created a spreadsheet for all new hires to ensure that they get the proper orientation upon hire.
Starting on 6/14/2024 [redacted] COO will ensure that all new hires get the proper orientation by using the

65b - Rights/Abuse 40 Hours (continued)

spreadsheet created.

Proposed Overall Completion Date: 08/06/2024

Licensee's Proposed Overall Completion Date: *09/11/2024*

NOT IMPLEMENTED 1/3/25 

65d - Initial Direct Care Training

9. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted] began providing unsupervised ADL services. However, this staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept (- 09/24/2024)***

On 6/13/2024 [redacted] COO put staff person A through the department approved direct care training course and competency test.
On 6/13/2024 [redacted] COO created a spreadsheet for all new hires to ensure that they get the proper orientation upon hire
Starting on 6/14/2024 [redacted] COO will ensure that all new hires complete the department approved direct care training course and competency test. [redacted] will track this by the certificates that are printed out, auditing the personnel files on a quarterly basis.

Licensee's Proposed Overall Completion Date: *08/06/2024*

Implemented (- 01/03/2025)

123b - Emergency Procedures Posted

10. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 09/24/2024)***

On 6/10/2024 [redacted] CEO posted the emergency procedures in a conspicuous and public place in the home.
6/13/2024 [redacted] CEO gave verbal education to administration about the emergency procedures being posted in a public and conspicuous place in the home.
Starting 7/1/2024 [redacted] CEO will check quarterly to ensure that the emergency procedures are still posted in the public and conspicuous place in the home.

123b - Emergency Procedures Posted *(continued)*

Licensee's Proposed Overall Completion Date: *08/06/2024* NOT IMPLEMENTED 1/3/25

132b - Safety Inspection/Fire Drill

11. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home has not had a fire safety inspection and fire drill observed by a fire safety expert in the past 12 months.

Repeat violation: 5/9/23 et al

Plan of Correction ***Directed (- 09/24/2024)***

On 6/13/2024 CEO gave verbal education on having a fire safety inspection and fire drill observed yearly to administration.
On 6/13/2024 COO got a hold of the Rocky Grove Fire Department to schedule the fire safety inspection and fire drill to be held in August 2024.
Starting on 7/1/2024 CEO will ensure that the fire safety inspection and fire drill are held yearly.

Proposed Overall Completion Date: 08/06/2024

DIRECTED PLAN
By 10/10/24: The administrator or designee shall develop and implement a tracking system to ensure that a fire safety inspection and observed fire drill and conducted annually and that documentation is kept.

Directed Completion Date: *10/10/2024*

Implemented (- 11/13/2024)

132c - Fire Drill Records

12. 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 fire drill record for the drills conducted on 3/30/24 and 4/14/24 do not include whether the time of the drill was AM or PM.

The fire drills conducted on the following dates do not include exit routes used:
** 9/30/23, at 9:49 pm.*
** 10/30/23, at 4:04 pm. and 8:37 pm.*
** 11/30/23, at 9:00 pm.*
** 12/30/23, at 9:45 pm.*

132c - Fire Drill Records (continued)

Plan of Correction ***Accept (- 09/24/2024)***

On 6/10/2024 gathered the fire drill paperwork and filled in the times and exits for the fire drills.
On 6/13/2024 CEO gave verbal education to administration on how to properly fill out the fire drill records.
Starting on 7/1/2024 CEO will audit fire drill records monthly to ensure they are filled out correctly.

Licensee's Proposed Overall Completion Date: *08/06/2024*

Implemented (- 11/13/2024)

141a 1-10 Medical Evaluation Information

13. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #4's medical evaluation, dated does not include medical or mental diagnosis and medication regimen. These areas are blank.

Plan of Correction ***Directed (- 09/24/2024)***

On 6/10/2024 CEO gave education to the medial liaison on how to properly do the medical evaluation.
On 6/13/2024 Medical Liaison redid the medical evaluation for resident #4 to ensure that it include medical and mental diagnosis and medication regimen.
Starting 7/1/2024 medical liaison will ensure that the medical evaluations are done correctly each time they are to be done.

Proposed Overall Completion Date: 08/06/2024

DIRECTED PLAN
By 10/10/24: The administrator or designee shall develop and implement a tracking system to ensure each resident has a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

141a 1-10 Medical Evaluation Information (continued)

Documentation of the tracking system shall be kept.

Directed Completion Date: *10/10/2024*

Implemented (- 01/03/2025)

141b1 - Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident #1's medical evaluation, dated does not include the resident's cognitive health function. This area is blank.

Plan of Correction ***Accept (- 09/24/2024)***

On 6/10/2024 CEO gave education to the medial liaison on how to properly do the medical evaluation.
On 6/13/2024 Medical Liaison redid the medical evaluation for resident #1 to ensure that it include medical and mental diagnosis and medication regimen.
Starting 7/1/2024 medical liaison will ensure that the medical evaluations are done correctly.

Licensee's Proposed Overall Completion Date: *08/06/2024*

Implemented (- 01/03/2025)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident #5 is prescribed multiple medications, including the following:

** Chlorpromaz, 50mg, 1 tab at bedtime for bipolar disorder*
** Diphenhydramine, 50mg, 1 capsule at bedtime for anxiety*
** Divalproex, 500mg, 1 tab every evening with supper and 3 tabs at bedtime for bipolar disorder*

However, these medications were not administered to resident #5 on 6/1/24 through 6/5/24 because these medications were not available in the home.

Repeat violation: 5/9/23 et al

Plan of Correction ***Directed (- 09/24/2024)***

On 6/10/2024 med Lead called the physician to get the new orders for the medications.
On 6/13/2024 meeting was held by med lead with all med techs to go over the process of medications reorder and how to ensure medications were always in house.
Starting on 7/1/2024 med lead will audit all medication carts and MARs monthly to ensure all

187d - Follow Prescriber's Orders (continued)

medications are in house.

Proposed Overall Completion Date: 08/06/2024

DIRECTED PLAN
By 10/10/24: The administrator or designee shall ensure that all currently prescribed medications for resident #5 are available for administration in the home.

Directed Completion Date: *10/10/2024*

Implemented (- 01/03/2025)

224a - Preadmission Screen Form

16. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #4's preadmission screening form, dated , does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident #5's preadmission screening form, dated , does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept (- 09/24/2024)***

On 6/10/2024 CEO updated the prescreens for residents #4 and #5 to show their needs could be met by the home.
On 6/13/2024 CEO gave verbal education to administration on how and why this needs to be done on all prescreens.
Starting on 7/1/2024 CEO will ensure that all prescreens are done in completion moving forward.

Licensee's Proposed Overall Completion Date: *08/06/2024*

NOT IMPLEMENTED 1/3/25

225a - Assessment 15 Days

17. 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 #5 was admitted on . However, resident #5's assessment, dated does not address the resident's history of as indicated in the resident's prescreen, dated and how this need will be met.

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept (- 09/24/2024)***

On 6/13/2024 CEO did a assessment update to resident #5s assessment to show history of .
On 6/13/2024 CEO gave verbal education to administration on how and why this needed to be done.
Starting 7/17/2024 Medical Liaison will ensure that all assessments are done in completion upon the 15-day admission deadline of all new residents.

Licensee's Proposed Overall Completion Date: *08/06/2024* NOT IMPLEMENTED 1/3/25

225c - Additional Assessment

18. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's assessment, dated , does not address the resident's behaviors of aggression and irritation toward resident #2 as indicated in staff interview.

Repeat violation: 8/10/23

Plan of Correction ***Directed (- 09/24/2024)***

On 6/13/2024 CEO did an assessment update for resident #1 to show aggressions.
On 6/13/2024 CEO gave verbal education to administration on how and why this is to be done with all assessments.
Starting 6/17/2024 medical liaison will ensure that all assessments are updated and audited on a monthly basis.

Proposed Overall Completion Date: 08/06/2024

DIRECTED PLAN
By 10/10/24 and at least monthly thereafter: The administrator or designee shall review resident assessments to ensure they include all personal care and behavioral needs of the residents. Documentation of these reviews shall be kept.

Directed Completion Date: *10/10/2024*

Implemented (- 01/03/2025)

227d - Support Plan Medical/Dental

19. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

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 #2's support plan, dated [redacted], does not address resident #2's aggression and agitation toward other residents, including resident #1 and document how this need will be met.

Plan of Correction ***Accept ([redacted] - 09/24/2024)***

On 6/13/2024 [redacted] CEO did an assessment update for resident #2 to show aggressions.
On 6/13/2024 [redacted] CEO gave verbal education to administration on how and why this is to be done with all assessments.
Starting 6/17/2024 [redacted] medical liaison will ensure that all assessments are updated and audited on a monthly basis.

Licensee's Proposed Overall Completion Date: *08/06/2024*

Implemented ([redacted] - 01/03/2025)

Facility Information

Name: *SUGAR VALLEY LODGE (WHISPERING PINES BUILDING)* **License #**: *44772* **License Expiration**: *08/10/2025*

Address: *178 SUGAR VALLEY LANE, FRANKLIN, PA 16323*

County: *VENANGO* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *SUGAR VALLEY LODGE INC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/20/2016* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *11/19/2024*

Inspection Dates and Department Representative

11/19/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *15* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *8*
Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

11/19/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/13/2024*

12/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/20/2024*
Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/20/2024*

Inspections / Reviews *(continued)*

01/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/21/2025*

65a - FS Orientation 1st Day

1. 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: (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable
(7) Telephone use and notification of emergency services

Description of Violation

Staff person A, whose first day of work was [REDACTED] and staff person B, whose first day of work was [REDACTED] did not receive orientation on the following topics:

** Smoking safety procedures*

** Telephone use and notification of emergency procedures*

Plan of Correction ***Accept ([REDACTED] - 01/02/2025)***

On 11/19/2024 [REDACTED] COO acknowledged that some of the trainings were missing from Staff person A and B files. Staff person A orientation was completed on 11/20/2024. Staff person B is no longer with the company. On 11/20/2024 [REDACTED] COO created a spreadsheet to track all documentation in the personnel files. Starting on 12/19/2024 [REDACTED] COO will start monthly audits of the personnel files to ensure all documentation is present.

Licensee's Proposed Overall Completion Date: *12/20/2024*

Not Implemented 1/22/25 [REDACTED]

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following: (1)Resident rights
(2)Emergency medical plan

Description of Violation

Staff person A and B completed [REDACTED] 40th scheduled work. However, these staff persons did not complete training in the following topics:

** Resident Rights*

** Emergency Medical Plan*

** Mandatory Abuse Reporting*

** Reportable Incidents and conditions*

Plan of Correction ***Accept ([REDACTED] - 01/02/2025)***

On 11/19/24 [REDACTED] COO Acknowledged that the trainings were not being documented for staff. Staff person A orientation was completed on 11/20/2024. Staff person B is no longer with the company. On 11/20/24 [REDACTED] COO created an audit form that has all the orientation requirements per regs. On 12/19/24 [REDACTED] CEO and [REDACTED] COO will audit all personnel files and make sure these trainings are added to the orientation Day 1 first 40 hours checklist.

Licensee's Proposed Overall Completion Date: *12/20/2024* Not Implemented 1/22/25 [REDACTED]

84 - Heat Sources

3. Requirements

2600.

84 - Heat Sources *(continued)*

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

Description of Violation

On 11/19/24, at 9:05 am., the temperature of the wall mounted heater in the entrance/lobby area was 230 degrees Fahrenheit and rising. There were no protective guards in place to prevent residents from coming into contact with the heater.

Plan of Correction ***Directed (- 01/02/2025)***

On 11/19/2024 CEO contacted county Maintenance to turn down heating unit.
On 11/19/2024 CEO checked lobby temperature to ensure it was at a comfortable temperature.
Starting on 12/19/2024 COO will audit the heating sources temperature weekly. COO will educate staff members on what to do when temperatures are too high.

Proposed Overall Completion Date: 12/20/2024

DIRECTED PLAN:
By 1/20/25: All staff persons will be educated on regulation 2600.84 including the home's procedures to ensure heat sources that exceed 120 degrees Fahrenheit and are accessible to residents are equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source. Documentation of the education shall be kept.

Directed Completion Date: *01/20/2025* Not Implemented 1/22/25

132d - Evacuation

4. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The most recent safe evacuation time specified in writing by a fire safety expert, in the letter dated 9/24/24, was 1 minute and 51 seconds However, the fire drill conducted on 10/30/24, at 1:50 pm. was completed in 3 minutes and 27 seconds.

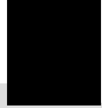
Plan of Correction ***Directed (- 01/02/2025)***

On 11/19/2024 COO acknowledged that safe evacuation time needed updated.
On 11/20/2024 COO contacted Rocky Grove Fire Department to change the safe evacuation time. Log was updated 11/20/2024.
Starting on 1/1/2024 COO will make sure all evacuation time are correctly done as well as the next years fire expert drills are scheduled.

Proposed Overall Completion Date: 12/20/2024

132d - Evacuation (continued)

DIRECTED PLAN:
By 1/20/25: The administrator or designee shall obtain a new safe evacuation time in writing from a fire safety expert, or the home shall complete an unannounced fire drill in 2 minutes 30 seconds or less. Future fire drills shall be completed within 2 minutes and 30 seconds or within the new safe evacuation time designated by the fire safety expert.

Directed Completion Date: *01/20/2025* Not Implemented 1/22/25 

225a - Assessment 15 Days

5. 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 #1's assessment, dated , does not include the resident's hallucinations and agitation issues. The assessment indicates the resident has no problem with these issues.

Plan of Correction ***Directed (- 01/02/2025)***

On 11/19/24 COO checked the initial assessment for Resident #1 and noticed that the symptoms were not listed on the RASP.
On 11/19/24 COO met with the Medical Assistant who is completing these Assessment and educated on ways to incorporate these symptoms into the RASP
On 12/19/24 COO will meet with Med Assistant weekly to go over RASPS being completed to make sure they have any and all needed information listed on the RASP.

The assessment was updated on 11/22/2024 by Med Lead .

Proposed Overall Completion Date: 12/20/2024

DIRECTED PLAN:
By 12/20/25: All staff persons who complete resident assessments shall be educated on regulation 2600.225a, including the need to include current diagnoses and behavioral needs on the assessment. Documentation of the education shall be kept.

Directed Completion Date: *01/20/2025* Not Implemented 1/22/25