pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: FEBRUARY 27, 2025

[REDACTED], CEO
Country Manor PCH LP
111 Altmeyer Drive
Kittanning, Pennsylvania 16201

RE: Country Manor
License/COC #: 44629

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 27, 2024, June 28, 2024, August 29, 2024, October 3, 2024, November 8, 2024, November 20, 2024 and December 4, 2024 et al. 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 44629) 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);(5) and 55 Pa. Code § 20.71(a)(2);(3);(4); (5);(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)
51	III	22	$3	$66	15 calendar days from mailing date of this letter
63(a)	II	22	$5	$110	5 calendar days from mailing date of this letter
103(e)	III	22	$3	$66	15 calendar days from mailing date of this letter
103(f)	III	22	$3	$66	15 calendar days from mailing date of this letter
107(c)	II	22	$5	$110	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 in writing 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:

[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.

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: *COUNTRY MANOR* **License #**: *44629* **License Expiration**: *12/11/2024*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRY MANOR PCH LP*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *32* **Waking Staff**: *24*

Inspection Information

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

Reason: *Complaint, Incident, Fine* **Exit Conference Date**: *07/10/2024*

Inspection Dates and Department Representative

06/27/2024 - On-Site: [redacted]

06/28/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *14*

Are 60 Years of Age or Older: *21*

Diagnosed with Mental Illness: *11*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *1*

Have Physical Disability: *0*

Inspections / Reviews

06/27/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/28/2024*

08/29/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/25/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/02/2024*

09/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/02/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/11/2024*

02/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/11/2024*

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

15a - Resident Abuse Report

1. 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 [redacted] resident #1 inappropriately touched resident #2 on the [redacted] causing resident #2 to become very upset, sad and angry and telling staff about the incident and calling the police. However, this allegation of abuse was not reported to the local Area Agency on Aging in accordance with the Older Adult Protective Services Act.

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

On 7-23-2024, Administrator reported the alleged incident to Older Adult Protective Services. Resident #1 claims they were having mutual feelings. This incident was not known to Administration until the day Inspectors came in. A form for listing all incident reports is going to be utilized for all incident reports. The form will list all incident reports, the name of the person, and if it should be reported, and finally if it was reported .Form to be used by Administrator or Designee was put into use 7-23-2024.A training by Regional Consultant is scheduled for all Staff on 7-30-2024 to do a training on abuse reporting as per regulation 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. Page 176 of the RCG was copied by Regional Consultant to hand out during training for Staff to keep as reference. The sign in sheet will acknowledge that they have had review of abuse reporting. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented ([redacted] - 02/01/2025)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], resident #4 was being evicted from the home due to not signing the resident-home contract. The police were called to assist in the eviction. This incident was not reported to the Department.

On [redacted], resident #1 inappropriately touched resident #2 on [redacted], causing resident #2 to become very upset, sad, and angry and telling staff about the incident and calling the police. This incident was not reported to the Department.

On [redacted], resident #3 fell while getting out of the shower and sustained a fractured right ankle. The resident was taken to a hospital for medical treatment. This incident was not reported to the Department.

Repeat Violation: 4/11/24 et al

16c - Written Incident Report (continued)

Plan of Correction ***Accept (- 08/14/2024)***

On 7-23-2024 Administrator sent incident reports to the Department for the 3 incidents above. Resident #4 no longer resides in Facility. Investigation was done by Administrator and Administrative Assistant on 7-23-2024 for the incident between Resident 1 & 2 with Resident #1 claiming it was mutual and apologizing when realizing it wasn't. They are very good friends. A training by Regional Consultant for all staff is scheduled for 7-30-2024 to include regulation 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).An incident reporting form will be reviewed with Staff by Administrator at the Staff meeting on 7-30-2024. Since 7-23-2024 Administrator has been keeping track of all incidents and documenting if it was reportable and needed sent. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *07/30/2024*

Not Implemented (- 02/01/2025)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

On , resident #3 fell resulting in a fractured right ankle, requiring ambulation in a wheelchair. Interviews indicate that staff are not assisting resident #3 and is being assisted by another resident. On 6/28/24, licensing representative observed staff watch another resident, who uses a wheeled walker, assisted resident #3 in wheelchair from the outside smoking area into the home after licensing representative asked if staff could assist resident #3.

Repeat violation: 2/1/24

Plan of Correction ***Accept (- 09/18/2024)***

Resident that was assisting Resident #3 was told is not permitted to push Resident #3 in wheelchair. was not happy about it, and had already been asked by Staff many times prior to this incident not to push Resident #3. A training is scheduled for 7-30-2024 by Administrator for all Staff, to include reg 2600. 23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan
A letter was composed by Regional Consultant on 7-24-2024 reminding all residents, that they are not permitted to assist with ADLs for any other residents. Some examples included on letter for clarity. The letter will be reviewed with all Residents at short Resident meeting on 7-30-2024. Staff will be instructed at Staff meeting on 7-30-2024 as to what Residents are not permitted to do.Documentation kept at Facility. Resident #2 was the Resident assisting Resident #3 with wheelchair. RASP was updated by Regional Consultant on 9-2-2024 to include defiance of some of the rules. Resident #2 was given a 30 day notice by Administrator on 8-24-2024 due to multiple issues and Resident not willing to work with Administration on correcting. Staff is aware and documenting all incidents.

23a - Activities of Daily Living Assistance (continued)

This is being disputed due to Staff never refusing assistance to Resident #3. Not sure how to put this, but the Resident involved in pushing Resident #3 is also involved in many of the other violations in this report. ██ craves attention all the time, and tells everyone that everything is ██ "right" even the fact ██ wants to push the Resident in ██ wheel chair.

Licensee's Proposed Overall Completion Date: *09/02/2024*

Not Implemented (██ - 02/01/2025)

25a - Written Contract and Review

4. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #4, admitted ██, did not have a resident-home contract completed.

Plan of Correction ***Accept (██ - 08/14/2024)***

Administrator on 2-5-24 presented the contract to Resident #4 (Never a Resident). Resident #4 refused to sign. ██ also refused to pay. ██ basically "squatted" in the home until ██ exit being escorted by police. Regional Consultant and Administrator called licensing and protective services many times for advice. We followed all of the steps that we were instructed to do even giving ██ a 30 day notice when ██ wasn't technically even a resident in the home. We took ██ as a Resident as a request from Area Agency on Aging due to ██ needing somewhere to stay. Administrator and Assistant checked all other Resident files on 7-23-2024 to be sure there was a signed and completed contract in each one. Documentation kept at Facility. Regional Consultant will be doing a training for Administration on 7-30-24 to include regulation 2600. 25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.
This is being disputed due to the fact that legally, this person was never a resident at the facility and the fact that we did everything as we were instructed to do. Our only fault was not kicking ██ out to the street which was one of the suggestions just to take ██ to a homeless shelter or something I have been doing this 24 years and if I have to resort to putting someone on the street that I know needs care, I could not live with myself. The day ██ was escorted out by police was because we were sending ██ to the hospital for health reasons, and ██ gave the ambulance driver a hard time so the police intervened and took ██ to the hospital to be evaluated.

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented (██ - 02/01/2025)

42b - Abuse

5. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b - Abuse *(continued)*

Description of Violation

On [redacted] resident #1 inappropriately touched resident #2 on [redacted], causing resident #2 to become very upset, sad, and angry and telling staff about the incident and calling the police. Resident #2 was tearful when telling the Department about the incident. Resident #1 admitted to the inappropriate touching of resident #2.

On [redacted], resident #5, a 2-person assist for transfers for safety, requested assistance out of bed to eat breakfast. The resident was left in bed and did not receive breakfast or lunch until approximately 2:00 pm. or 3:00 pm. that day. This was observed by staff and the Ombudsman, who had to intervene and tell staff to feed the resident. Staff interviews indicated that the resident is often left in bed all morning and afternoon by staff.

Plan of Correction ***Directed ([redacted] - 09/23/2024)***

Resident #1 truly thought the incident was mutual. [redacted] apologized to Resident #2 and they have become good friends. Protocol is to keep them separated, but they are not happy about it. At this point Staff are to keep them separated as much as possible. Resident #5 has had some deterioration, and is on Hospice. [redacted] always came out by [redacted] to the dining room. The staff were made aware of the situation of [redacted] not eating by Administrator and they had some dispute with it. It was remembered that the Ombudsman asked Staff to feed the resident, but it was a bowl of cereal at 9:15 AM not the afternoon as stated in this violation. A training is being scheduled for all Staff by Protective Services to include regulation 2600. 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. The date will be determined September 3 by Regional Consultant after [redacted] can reach the Area Agency On Aging. The Contact was not available by the time this report was received and is closed Monday, September 2. A Quality management meeting is scheduled for 7-30-2024 for Regional Consultant, Assistant, Administrator and Administrative Assistant to discuss further available options to be informed of any allegations of abuse

Proposed Overall Completion Date: 09/05/2024

DIRECTED STEP
By 10/10/24: All staff persons shall be educated in resident abuse and abuse reporting by a Department-approved outside source. Documentation of the education shall be kept.

Directed Completion Date: *09/05/2024*

Not Implemented ([redacted] - 02/01/2025)

42l - Personal Clothing

6. Requirements

2600.
42.l. A resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions.

Description of Violation

Multiple residents, to include residents #2, #6, and #7, indicated that multiple clothing items have not been returned to them after laundering.

42l - Personal Clothing *(continued)*

Plan of Correction ***Accept (- 08/14/2024)***

On 6-29-2024 Housekeeper worked with Residents # 2, 6 & 7 to find where their missing pieces of laundry were. A training for all staff will be done on 7-30-2024 by Administrator to include reg 2600. 42.l. A resident has the right to furnish room and purchase, receive, use and retain personal clothing and possessions. 'Lost Found" tickets were created by Regional Consultant to be used by Residents when they are missing a personal item or clothing. They will be kept on the bulletin board in a marked envelope with instructions of where to turn in. This will be implemented after Residents are notified and trained on procedure by Regional Consultant on 7-30-24. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented (- 02/01/2025)

51 - Criminal Background Check

7. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, hired has a Pennsylvania criminal background check under review, however, this staff person has been working in the home unsupervised on and

Staff person B, hired has no current Pennsylvania criminal background check completed since however, this staff person has been working in the home providing unsupervised direct care on and

Repeat violation: 4/11/24 et al, 3/12/24, 10/19/23 et al

Plan of Correction ***Accept (- 08/29/2024)***

All other staff files were reviewed by Administrator on 6-28-2024 for accuracy. Staff Person A no longer works at Facility. had started 1 day prior to inspection and had the background check done on first day of hire as regulation asked for. Staff person B was an employee for several years. left on and returned in 2024. original date of hire and background check was with no record. 2nd one at DHS request was done day of inspection 6/27/2024 with no record. A training by Administrator is scheduled for 7-30-2024 to cover regulation 2600. 51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults). Documentation kept at the Facility

This is being disputed due to being in the correct guidelines. Staff person A had a background check done and was pending. Per RCG regulation the employee can work provisionally up to 30 days, Staff person B was only away from job for a little over a month. Due to the short amount of time, this would be considered continuous employment Documentation available

Licensee's Proposed Overall Completion Date: *07/30/2024*

Not Implemented (- 02/01/2025)

60a - Staff/Support Plan

9. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home has 31 residents in the home, including resident #5, who requires 2-person assist in transfers for safety. However, the staff schedule indicates on the following dates and times, the home only had one staff person working:

** 5/1/24 from 10:00pm.-6:00am., 5/30/24 from 6:00pm.-6:00am., and 5/31/24 from 6:30pm.-6:00am.*
** 6/1/24 from 6:00pm.-6:00am. and 6/2/24 from 6:00pm.-6:00am.*

Plan of Correction ***Accept (- 09/18/2024)***

All Staff schedules were reviewed by Administrator on 6-28-2024. All shifts were covered with the required amount of hours. Each schedule will now be reviewed by Administrator or Designee and any external Staffing will be added to the bottom of the schedule with proof of staffing agency on the dates and times they worked. A training is scheduled for 9-4-2024 by Regional Consultant with all Staff involved in the scheduling process.Documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 02/01/2025)

65a - FS Orientation 1st Day

10. 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:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was , did not receive any of the orientation required.

Plan of Correction ***Accept (- 08/29/2024)***

On 6-28-2024 staff person b's file was pulled by DHS. had original training from date of hire , but there was also a training for first day of work dated . All other staff files were reviewed by Administrator and Assistant for accuracy. Documentation kept at Facility. The training for all staff by Administrator is scheduled for 7-30–2024 with regulation 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:
1. Evacuation procedures.

65a - FS Orientation 1st Day (continued)

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

This is being disputed due to the training being done on [redacted] current first day of work.Both [redacted] old and new first day of work papers are in [redacted] file

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented ([redacted] - 02/01/2025)

65b - Rights/Abuse 40 Hours

11. 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 B completed [redacted] 40th scheduled work hour. However, this staff person did not receive any of the orientation required.

Plan of Correction ***Accept ([redacted] - 08/29/2024)***

On 6-2-2024 staff person B's file was pulled by DHS. [redacted] had [redacted] original training for the first 40 hours of work dated [redacted] but also had the first 40 hour training dated [redacted]. All other staff files were reviewed by Administrator and assistant on 6-29-2024 for accuracy. documentation kept at facility a training will be held on 7-30-2024 by Administrator for all staff to include regulation 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.
This is being disputed due to Staff person B having all the correct training within [redacted] first 40 hours. Both the old date and new date are in [redacted] file

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented ([redacted] - 02/01/2025)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 6/28/24, at approximately 12:00 pm.- 4:45 pm., macaroni and cheese served for lunch was scattered throughout the dining room area.

Repeat violation: 10/19/23 et al

Plan of Correction ***Accept (- 08/29/2024)***

On 6/28/2024 DCS vacuumed after the dinner meal. They are accustomed to vacuuming after each meal, but there are times when other things, such as Resident care come first. A training will be done by administrator for all staff on 7-30-2024 to include regulation 2600. 85.a. Sanitary conditions shall be maintained. Administrator or Designee will do daily walkthroughs with documentation to check for sanitary conditions beginning 7-23-2024

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented (- 02/01/2025)

85d - Trash Receptacles

13. 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 6/27/24, at approximately 10:00 am., there was a partially full, uncovered, unattended trash can in the shared bathroom of bedrooms #2, #16, and #14.

Repeat violation: 3/12/24, 2/1/24, 10/19/23 et al

Plan of Correction ***Accept (- 08/29/2024)***

On 6-27-2024, day of inspection, housekeeper emptied the uncovered trash cans in rooms #2, #16 and #14. also put trash cans with lids on in each one. On 6-28-2024 housekeeper checked all other trash cans to be sure they met regulations. A training is scheduled for 7-30-2024 by administrator for all staff to include regulation 2600. 85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents. Beginning 7/23/2023 Administrator or designee, will check bathrooms and kitchen area daily to be sure the trash cans meet regulations. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *07/30/2024*

Not Implemented (- 02/01/2025)

88a - Surfaces

14. 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 6/28/24, there was an approximate 2"x 4" area of carpet in the threshold of bedroom #2 that is ripped, rolling up

88a - Surfaces (continued)

and fraying, causing a potential trip/fall hazard.

Repeat Violation: 12/21/23

Plan of Correction ***Accept (█ - 08/29/2024)***

On 7-23-2024 Administrator repaired the frayed carpet in the threshold of bedroom #2. A training by Administrator is scheduled for 7/30/24 to include regulation 2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.Beginning 7-22-2024 Administrator or designee will do daily walk-throughs with documentation. Any areas in need of repair will be done at that time if possible if not, it will be marked on the documentation when it is completed.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented (█ - 02/01/2025)

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 6/27/24 and 6/28/24, there was no bed linen on resident #8's bed. Interviews indicate that the bed has had no linen on it for approximately one month.

Plan of Correction ***Accept (█ - 08/29/2024)***

On 6-28-2024 housekeeper supplied Resident #8 with new bed linens. █ was shown where the extra linens are kept, in case █ needs them more often. █ is very vocal about everything, but did not mention to Staff. Administrator will have staff document when linens are changed beginning 7/30/2024. Changes will be made on shower day. Documentation kept at facility. A training is scheduled for 7/30/2024 by Administrator for all staff on regulation 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.

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented (█ - 02/01/2025)

103e - Left Overs

16. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 6/27/24, there were multiple plastic containers that were unlabeled, undated in refrigerator of the black refrigerator/freezer in the kitchen.

103e - Left Overs (continued)

Repeat Violation: 3/12/24, 10/19/23 et al

Plan of Correction ***Accept (- 08/29/2024)***

On 6/27/2024 kitchen help disposed of the food in the plastic containers that were on labeled and undated. On 6/27/2024 all other leftovers were checked by kitchen help to be sure they were in a sealed container and labeled. A training scheduled by Administrator for all staff on 7/30/2024 to include regulation 2600. 103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated. Beginning 7-22-2024 kitchen help or designee will check daily that all leftovers are in a sealed container and dated. documentation kept at the facility.

This is being disputed due to the black refrigerator being a Staff only refrigerator with a clear large sign on front stating that it is for Staff only.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Not Implemented (- 02/01/2025)

103f - Refrigerator/Freezer Temps

17. Requirements

2600.
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 6/27/24, at 10:34 am., the temperature in the refrigerator of the white refrigerator/freezer in the kitchen was 42 degrees Fahrenheit.

Repeat violation: 3/12/24, 10/19/23 et al

Plan of Correction ***Accept (- 08/29/2024)***

A new operable thermometer was placed in the white refrigerator on 6-27-2024 by Administrator. All other refrigerator/freezers were checked for correct temperature by Administrator same time. Administrator or Designee will check all thermometers daily X 3 months beginning 7-1-2024 to ensure thermometers are in working order. Documentation kept. Staff training for all staff by Administrator is scheduled on 7-30-2024 to include regulation 2600. 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. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *07/30/2024*

Not Implemented (- 02/01/2025)

187b - Date/Time of Medication Admin.

18. 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 #10 is prescribed Lantus Solostar, 100UM/ML, inject 14 units at bedtime. Resident #10's June 2024

187b - Date/Time of Medication Admin. (continued)

medication administration record (MAR) does not include the initials of the staff person who administered the Lantus on 6/6/24, at 9:00 pm.

Resident #11 is prescribed Pantoprazole SOD, 20mg, 1 tablet once daily. Resident 11's June MAR does not include the initials of the staff person who administered the Pantoprazole on 6/1/24 and 6/21/24, at 7:30 pm.

Repeat Violation: 4/11/24 et al, 10/19/23 et al

Plan of Correction ***Accept (- 09/23/2024)***

A training is scheduled for all med techs on 7-30-204 by the Regional Consultant. Regional Consultant will include re-training on recording med passes as soon as med is given to Resident and training the administrator and med techs to do MAR audits using Tabula Pro to keep in compliance with regulation 2600.187b. Administrator or designee will do all MAR audits between 7-30-2024 & 8-6-2024 then weekly thereafter. Documentation kept at the facility.

Proposed Overall Completion Date: 09/02/2024

Licensee's Proposed Overall Completion Date: *09/02/2024*

Not Implemented (- 02/01/2025)

225a - Assessment 15 Days

19. 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 #4 was admitted on however, the resident's assessment was not completed until

Resident #2 was admitted on ; however, the resident's assessment was not completed until

Repeat Violation: 10/19/23 et al

Plan of Correction ***Accept (- 09/23/2024)***

Resident #4 was never a Resident (refused to pay or sign contract) and No longer resides in Facility. Resident #2 came from a facility that sent a current assessment with and it was used until the current one that was done at 17 days after being admitted. All other assessments are being reviewed by Administrator and assistant to be sure that they are in compliance. The reviews will be finished by 7-30-2024. A training by Administrator is scheduled for 7-30-204 for all staff on regulation 2600.225a. 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. Documentation kept at the facility. When a resident is admitted, it has been discussed between the Regional Consultant & Administrator to keep the file on the desk until everything is completed and then file it in the file cabinet.

Licensee's Proposed Overall Completion Date: *09/02/2024*

225a - Assessment 15 Days *(continued)*

Not Implemented (- 02/01/2025)

225c - Additional Assessment

20. 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 #3's assessment, dated does not include the resident's change in mobility needs, requiring assistance in transferring, ambulating, and toileting due a fractured of the right ankle occurring on

Repeat Violation: 10/19/23 et al, 7/11/23

Plan of Correction ***Accept (- 08/29/2024)***

On 7-23-2024 Administrator updated RASP for Resident #3 to include the temporary change in mobility requiring assistance in transferring, ambulating and toileting due to a fractured right ankle. All other RASPS were reviewed by Administrator and Assistant on 6-28-2024 to see if any updates were missed, and add addendums or significant changes if needed. A form created by Regional Consultant will be implemented 7-30-2024 directly after training. The form will be used by the staff to report anything new with a resident. There are many options there. The form will then be given to the administrator or designee to address. Any changes needed by Residents will be done at that time by Administrator or Designee. A training for all staff by Administrator is being held on 7-30-2024 to include a reporegulation 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.

Licensee's Proposed Overall Completion Date: *07/30/2024*

Not Implemented (- 02/01/2025)

228b - Discharge or Transfer

22. Requirements

2600.
228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

Description of Violation

On 5/31/24, the home called the police requesting their assistance to evict resident #4 from the home for failure to sign contract. However, the home did not provide a 30-day advance written notice to the resident.

Plan of Correction ***Accept (- 08/29/2024)***

A training will be done by Regional Consultant for Administrator and Assistant on 7-30-2024 to include this

228b - Discharge or Transfer (continued)

regulation: 2600.228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.Documentation kept at Facility. The Home does not initiate a 30 day notice regularly, but Administration is aware there must be a 30 day notice given.

This is being disputed due to the fact that there is a 30 day dated notice in her file.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented (█ - 02/01/2025)

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

Facility Information

Name: *COUNTRY MANOR* **License #**: *44629* **License Expiration**: *12/11/2024*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRY MANOR PCH LP*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *30* **Waking Staff**: *23*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *09/13/2024*

Inspection Dates and Department Representative

08/29/2024 - On-Site:

09/03/2024 - Off-Site:

09/12/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *21*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

08/29/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/13/2024*

11/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/05/2024*

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

11/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/05/2024*

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

02/01/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *12/05/2024*

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

51 - Criminal Background Check

1. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired however, a Pennsylvania State Police Criminal Background Check was not completed for this staff person until Repeat Violation: 3/12/2024, 10/19/2023 et al

Plan of Correction ***Accept (- 11/04/2024)***

Staff person A was a recent former Employee that came back after a very short absence. A new Background check was completed by Administrator on . Administrator and Administrative Assistant reviewed all current employees files on 8/30/24. Training for all staff by Administrator on 10/17/24 on POC Reg 2600.51: "Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults)." Documentation will be kept in the facility.

Licensee's Proposed Overall Completion Date: *10/21/2024*

Not Implemented (- 02/01/2025)

56 - Admin 20 Hours/Week

2. Requirements

2600.
56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

Description of Violation

The home has not had a qualified administrator since 8/9/24.

Plan of Correction ***Accept (- 11/18/2024)***

On previous Administrator quit. As of , new administrator was hired. There is an Administrator working a minimum of 20 hours in the facility. Administrator is tracking hours worked as per Reg 2600.56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month. Staff training with all Staff including incoming Administrator and Assistant on Documentation will be held at the facility. Beginning 9-1-2024, interim Administrator has been Documenting Administrator hours on Desk Calendar and payroll sheet bi-weekly. Interim Administrator reviewed the process of documenting hours with the Incoming Administrator. The process will document the required weekly hours.

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

Not Implemented (- 02/01/2025)

85a - Sanitary Conditions

3. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

At 9:35 a.m., the refrigerator section of the kitchen's white refrigerator/freezer had sticky substances and food particles on all the shelves and under the drawers throughout the refrigerator.

At 10:15 a.m., the floor below the shelf in the dry food storage room was covered with a clear, sticky liquid and multiple food particles.   Repeat Violation: 10/19/23 et al

Plan of Correction ***Accept (- 11/18/2024)***

On 8/29/2024, Housekeeper cleaned all areas that were in violation. All other areas will be monitored daily beginning 9-1-2024 by Administrator or Designee for Sanitary conditions. Staff Training by Interim Administrator on 10/17 with all staff on Reg 2600.85.a "Sanitary conditions shall be maintained. All Documentation will be kept at the facility

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

Not Implemented (- 02/01/2025)

85b - Infestation

4. Requirements

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

Description of Violation

At 9:30a.m., approximately 30 flies/flying bugs were in direct contact with food stored in the kitchen.
Repeat Violation: 10/19/23 et al

Plan of Correction ***Accept (- 11/18/2024)***

On 8/29/24, All foods that were attracting fruit flys were disposed of by the housekeeper. The Kitchen was deep cleaned by house keeper on 8/30/24. All other food areas were checked by Administrator for infestation on 8-30-2024. A training was done for all staff on 10/17/24 by Administrator On Reg 2600.85.b. Documentation of weekly walk throughs by Administrator or designee staff beginning 9-1-2024 are being kept in the facility.

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

Not Implemented (- 02/01/2025)

85e - Trash Outside Home

5. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

From 9:00 a.m. until 1:30 pm, 2 large dumpsters in the rear of the home were ¼ to ½ filled with trash and the lids were open.

Plan of Correction ***Accept (- 11/18/2024)***

On 8/29/24, Administrator shut the two dumpster lids. On 8-30-2024, Administrator posted a sign to remind employees to shut dumpster lids. It is Posted on Door near dumpster location Staff training on POC done on

85e - Trash Outside Home (continued)

10/17/24 by the Administrator on Reg 2600 85.e "Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.".Documentation of weekly Walk throughs beginning 9-1-2024 by Administrator or designee being kept in the facility.

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

Not Implemented (- 02/01/2025)

95 - Furniture and Equipment

6. Requirements

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

Description of Violation

The hot water faucet on the sink in bedroom #25 was in disrepair, causing water to run continuously.

Plan of Correction ***Accept (- 11/04/2024)***

On 8/30/24, A maintenance man repaired the faucet on the sink in Bedroom #25. All the other bathroom faucets were checked by the maintenance man at that time and repaired. Training by Administrator on 10/17/24 for all staff about violation on Reg 2600 95 "Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards. " Daily building walk throughs beginning 9-1-2024 by administrator / designee will help ensure any problems get noticed , documentation will be keep at the facility

Licensee's Proposed Overall Completion Date: *10/28/2024*

Implemented (- 02/01/2025)

103b - Clean/Sanitized Kitchen Surfaces

7. Requirements

2600.
103.b. Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal.

Description of Violation

At 9:35 a.m., a foul smell emitted from a moist and sticky liquid on the kitchen counter to the right of the sink.

Plan of Correction ***Accept (- 11/04/2024)***

The foul smell was from the box of tomatoes on kitchen counter that were rotten. The housekeeper disposed of the box of tomatoes on 8/29/24. and checked and cleaned the rest of the kitchen surfaces for sanitation. Training on Reg 2600 130.b "Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal." for all staff members on 10/17/24. Daily walk throughs beginning 9-1-2024 are being done by Administrator /designee. On 9-1-2024, Administrator hired/promoted a new cook for 5 days a week and has training the current cook on sanitation in the kitchen.. Alll Documentation will be kept at the Facility

Licensee's Proposed Overall Completion Date: *10/28/2024*

Implemented (- 02/01/2025)

103c - Food Protected

8. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

103c - Food Protected *(continued)*

Description of Violation

At 9:50 a.m., a large box of tomatoes on the kitchen counter next to the sink were in varies stages of decay and covered with mold. Multiple flying insects were on and around the tomatoes.

Plan of Correction ***Accept (- 11/04/2024)***

The foul smell was from the box of tomatoes on kitchen counter that were rotten. The housekeeper disposed of the box of tomatoes on 8/29/24. and checked and cleaned the rest of the kitchen surfaces for sanitation. Training by Administrator on Reg 2600 130.c"Food shall be protected from contamination while being stored, prepared, transported and served.." for all staff members on 10/17/24. Daily walk throughs beginning 9-1-2024 are being done by Administrator /designee. On 9-1-2024, Administrator hired/promoted a new cook for 5 days a week and is training current cook on sanitation in the kitchen.. Alll Documentation will be kept at the Facility

Licensee's Proposed Overall Completion Date: *10/28/2024*

Implemented (- 02/01/2025)

103d - Storing Food Off Floor

9. Requirements

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

Description of Violation

At 9:35 a.m., a 50 pound bag of rice and 50 pound bag of brown sugar were stored on the kitchen floor next to the stove.

Plan of Correction ***Accept (- 11/19/2024)***

On 8/30/24, Rice and brown sugar were disposed of by the housekeeper. All other food storage areas were checked and confirmed to be off the floor. Staff Training by Interim Administrator on 10/17/24 for all staff on Reg 2600 103.d "Food shall be stored off the floor."Daily building walk thru's by Administrator/designee beginning 9–2024 are being done and new cook began working in kitchen on 10-14-2024. Documentation will be kept in the facility.

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

Implemented (- 02/01/2025)

103e - Left Overs

10. Requirements

2600.
103.e. Food served and returned from an individual’s plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 9:30 a.m., the freezer section of the kitchen's black refrigerator/freezer contained the following unlabeled and undated items:

* *Two 5 pound bags of nugget shaped meat product*
* *Two 5 pound bags of a patty shaped meat product*
* *One 1 gallon bag of an unknown product*

Repeat Violation: 3/12/24, 10/19/23 et al

Plan of Correction ***Accept (- 11/19/2024)***

On 8/30/24, all unmarked left overs were disposed of by the housekeeper. Administrator had a training on reg

103e - Left Overs (continued)

2600 103.e"Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated." with all staff. Daily walk throughs beginning 9-1-2024 by Administrator / or Designee are being conducted. New cook began [redacted] who is training old cook. All documentation will be kept at the facility.

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

Not Implemented ([redacted] - 02/01/2025)

103f - Refrigerator/Freezer Temps

11. Requirements

2600.
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

At 9:30 a.m. the thermometer in freezer section of the kitchen's black refrigerator/freezer was inoperable.
At 10:15 a.m., there were no thermometers in the 2 milk coolers in the dining room.
Repeat Violation: 3/12/2024, 10/19/2023 et al

Plan of Correction ***Accept ([redacted] - 11/19/2024)***

On 8/30/24, All thermometers were checked by the housekeeper, all non working thermometers were disposed of and replaced with new ones. A list generated by Admiinistrator Will be used to check daily temps on all refrigeration by the kitchen help recording temps beginning 9-1-024. Staff training on Reg 2600 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." done on 10/17/24 by Administrator . Log sheets will be reviewed by Administrator/ Designee and kept at facility for documentation.

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

Not Implemented ([redacted] - 02/01/2025)

103g - Storing Food

12. Requirements

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

Description of Violation

At 9:30 a.m., the freezer section of the kitchen's black refrigerator/freezer contained the following opened, unsealed items:

** Two 5 pound bags of nugget shaped meat product*
** Two 5 pound bags of a patty shaped meat product*
** One 1 gallon bag of an unknown product*

At 9:35 a.m., a 50 pound bag of rice and a 50 pound bag of brown sugar were open and unsealed, and multiple flying insects were seen coming from each bag.

At 9:35a.m. the following items were open and unsealed in the upper cabinet next the kitchen's black refrigerator/freezer:

103g - Storing Food (continued)

* *One bag of macaroni noodles*
* *One bag of white cake mix*
* *One bag of long grain rice*

Plan of Correction ***Accept (- 11/19/2024)***

on 8/30/24, all open items were disposed of, Housekeep went thru cabinets to ensure all other items were properly sealed and stored.. Housekeeper did a cleaning in the kitchen to sanitize cabinets. Staff training on 10/17 by Administrator on reg 2600 103.g "Food shall be stored in closed or sealed containers." Walk thrus beginning 9-1-2024 are being done daily by Administration/ Designee to find any issues.. Administration is working on getting better storage containers. Documentation being keep at the Facilitky

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

Not Implemented (- 02/01/2025)

103i - Outdated Food

13. Requirements

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

Description of Violation

At 10:00 a.m. two 1 gallon jugs of milk with sell by dates of 8/6/24 and 8/21/24 were stored in the dining room milk cooler. Both jugs were swollen and unable to sit upright. Repeat Violation: 3/12/2024, 10/19/2023 et al

Plan of Correction ***Accept (- 11/04/2024)***

Immediately, on 8/29-2024, Milk was disposed of by Housekeeper. On 8-30-2024, All milk containers were pulled by Housekeeper on 8-0-2024 from the cooler and reviewed to make sure they were good, Housekeeper cleaned/ sanitized cooler and placed good milk back in cooler with the oldest milk on the top to be used first(before expiration) Staff training for all Staff held by Administrator on 10/17/24 on Reg 2600 103 i "Outdated or spoiled food or dented cans may not be used." Daily Walk throughs beginning 9-1-2024 by administration/Designee will be done. Documents will be kept at the facility

Licensee's Proposed Overall Completion Date: *10/28/2024*

Implemented (- 02/01/2025)

161a - Meals

14. Requirements

2600.
161.a. Meals shall be offered that meet the recommended dietary allowances established by the United States Department of Agriculture.

Description of Violation

On 8/27/24, the home served hot oatmeal for breakfast, grilled cheese for lunch, and lasagna soup for dinner. The meals served did not meet the recommended dietary allowance established by the United States Department of Agriculture to include vegetables.

On 8/28/24, the home served pancakes and cold cereal for breakfast, cold cut sandwiches for lunch, and hotdog on a bun with potato chips for dinner. The meals served did not meet the recommended dietary allowance established by the United States Department of Agriculture to include vegetables.

161a - Meals (continued)

Plan of Correction ***Accept (█ - 11/19/2024)***

On 9-1-2024 New menus were created by Regional Assistant to include 8 weeks menus to be alternated. The menus have been reviewed by Administrator for recommended daily nutritional allowances. Staff training on Reg 2600 161.a "Meals shall be offered that meet the recommended dietary allowances established by the United States Department of Agriculture." by Administrator on 10/17/24.. Beginning 9-1-2024, Administrator will review menus and edits to menus weekly to ensure compliance with reg.161.a. Beginning 10-14-2024 There is a new/promoted cook 5 days a week that is aware of regulatory compliance. Documentation kept at Facility.

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

Implemented (█ - 02/01/2025)

162e - Menu Changes

15. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 8/29/24 at 1130 a.m., the home served lasagna soup, corn, and buttered bread for the lunch meal. However, the menu posted indicated, "chef's choice" and the residents were not notified prior to the meal of what the "chef's choice" meal would be. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept (█ - 11/04/2024)***

"Chefs Choice" is left overs and if none are available, cook will prepare their choice of food for the lunch meal. The Residents have always looked forward to the variety. Staff training on 10/17/24 by Administrator on Reg 2600 162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy). When we have "Chefs Choice" on the menu.... the meal is posted on our white board in dining room as to what the options are , so the residents can see what is available . Documents will be kept at the facility. This is being disputed as the Facility has always had chefs choice and posts on board by cook in the mornings. The menu with the lasagna soup, (which was a new item that Residents loved), was one of the leftovers from the day before the chefs choice. There were also other choices available and relayed to Residents ahead of meal.

Licensee's Proposed Overall Completion Date: *10/28/2024*

Not Implemented (█ - 02/01/2025)

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

Facility Information

Name: *COUNTRY MANOR* **License #**: *44629* **License Expiration**: *12/11/2024*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRY MANOR PCH LP*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *27* **Waking Staff**: *20*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *10/15/2024*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *26*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *19*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

10/03/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/15/2024*

Inspections / Reviews *(continued)*

12/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/14/2025*

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

01/07/2025 - POC Submission

Submitted By: [redacted] *r* **Date Submitted:** *01/14/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/15/2025*

02/01/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/14/2025*

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

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

The License Inspection Summary, dated 10/19/23 et al, was not posted in a conspicuous and public place in the home.

Repeat Violation: 10/19/23 et al

Plan of Correction ***Accept (- 12/06/2024)***

On 10-4-2024 Administrator checked the postings on the wall and verified the 10-19-23 license was posted in a conspicuous public place. A training by Interim Administrator is scheduled for 11-22-2024 for all Staff on regulation 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. Beginning 11-20-2024 Administrator will do weekly checks with documentation to be sure current licensing papers and updates are posted in a public place.
This is being disputed due to the fact that the license for 10 19-23 was posted as it was supposed to be. You will be able to go back through past inspections to see that it was OK for the whole year. There was a new person on staff that day, and had not been trained where the postings were yet the incoming administrator was in class when the inspector came.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented (- 02/01/2025)

18 - Compliance With Laws

2. 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

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The home did not have a carbon monoxide detector outside of the furnace room across from bedroom #20 where the home's gas furnace and hot water heater are located.

Plan of Correction ***Accept (- 01/07/2025)***

Administrator purchased CO2 detector and had installed on 10/4/2024. Administrator will hold a training for staff on the Regulation 2600.18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations on 11/22/24. CO2 detector will be monitored for battery check in Oct 2025 or when it needs replaced.

18 - Compliance With Laws *(continued)*

Licensee's Proposed Overall Completion Date: *12/10/2024*

Implemented (- 02/01/2025)

63a - First Aid/CPR Training

3. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 9/28/24, 25 residents were present in the home. During this time, staff person A was the only staff person present in the home from 6:00p.m. to 7:45a.m. on 9/29/24. Staff person A is not trained in first aid and certified in obstructed airway techniques and CPR.

Repeat Violation: 3/12/24, 10/19/23 et al

Plan of Correction ***Accept (- 01/07/2025)***

Administrator set up a class on November 21st for CPR/First Aide training for all staff that is not certified with Monarch. Staff Training on Requirement 2600.63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times on 11/22/24 by Administrator. Administrator will review all scheduled starting November 21, weekly to confirm that all shifts are covered with cpr/first aide training

Licensee's Proposed Overall Completion Date: *12/10/2024*

Not Implemented (- 02/01/2025)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

A brown sticky substance was on the shelf in the door and on the floor of the refrigerator section of the kitchen's white Frigidaire refrigerator/freezer.

A black substance of what appeared to be mold/mildew covered the bottom of the cabinet under the kitchen sink.

There were multiple food particles and pasta noodles on the floor behind the stove in the kitchen.

Repeat Violation: 10/19/2023 et al

85a - Sanitary Conditions (continued)

Plan of Correction ***Accept (- 01/07/2025)***

Housekeeper cleaned the areas in violation on 12-6-2024 with inspectors present. Direct Care Staff did a deep clean in the kitchen on 10/4/2024 and 10//5/2025. Administrator moved a different staff member into the Kitchen on 10/7/2024
Administrator will hold training for all staff on Regulation: 2600.85.a. Sanitary conditions shall be maintained on November 22, 2024.for all staff. Walk throughs are being done daily to confirm items are being maintained, Administrator is getting 2bids for repair of kitchen sink and issues. Leak issue was completed by Plumbing on 11/19/24. Working on getting other issues fixed with a contractor, plan to have completed by 12/20/24.
Proposed Overall Completion Date: 12/20/2024

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

Not Implemented (- 02/01/2025)

5. Requirements

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

Description of Violation

There was a strong odor of urine in bedrooms #2 and #3.

Repeat Violation: 3/12/24, 2/1/24, 12/21/23, 10/19/23 et al, 7/11/23

Plan of Correction ***Accept (- 01/07/2025)***

Direct care staff is prompting two hour potty useage 0n 10/6/24. Staff is doing daily laundry for these rooms.
Administrator is training on regulation: 2600.
85.a. Sanitary conditions shall be maintained. on November 22,2024.for all staff. 0n 10/10/24 Administrator or Designee will do daily walk thru to ensure sanitary issues are being completed.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (- 02/01/2025)

6. Requirements

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

Description of Violation

There was an unlabeled/used washcloth on the towel rack in the bathroom shared by bedrooms #3 and #4.

There was an unlabeled/used washcloth on the towel rack in the bathroom shared by bedrooms #16 and #17.

85a - Sanitary Conditions (continued)

Plan of Correction ***Directed (█ - 01/07/2025)***

Admin Assistant made label for each resident. on 11/18/24 Labels were place in each bathroom that a resident uses. Administrator will do training on regulation: 2600.
85.a. Sanitary conditions shall be maintained for all staff. Administrator or designee will provide labels when we get new residents starting on nov 22,2024.
Will add To daily walk throughs to check bathrooms to ensure there are no unlabeled washcloths present by Admin or designee starting Nov 22, 2024. And documentation will be kept at the facility.

Proposed Overall Completion Date: 12/13/2024

Directed:
By 1/15/25, the Administrator will do training on regulation: 2600 85.a. - Sanitary conditions shall be maintained for all staff.
█ ***1/7/25***

Directed Completion Date: *01/15/2025*

Implemented (█ - 02/01/2025)

7. Requirements

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

Description of Violation

There were no paper towels, mechanical air blower, individual cloth towels or other sanitary means of hand drying in the bathroom shared by bedrooms #3 and #4.

There were no paper towels, mechanical air blower, individual cloth towels or other sanitary means of hand drying in the bathroom shared by bedrooms #16 and #17.

Plan of Correction ***Accept (█ - 01/07/2025)***

Direct Care staff put a roll of paper towels in all the resident bathrooms on nov 13,2024. Administration is holding training with staff on Regulation 2600.85.a. Sanitary conditions shall be maintained on November 22,2024. Cleaning staff will put a roll of paper towels in the rooms when █ is cleaning the bathrooms,daily if needed. starting 11/13/24. on 11/13, Designee staff will confirm when doing daily walk thrus.that towels ln the bathrooms

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (█ - 02/01/2025)

85b - Infestation

8. Requirements

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

Description of Violation

Approximately 15 flies were present in the kitchen area where food was being thawed and prepared

85b - Infestation (continued)

Repeat Violation: 10/19/23 et al

Plan of Correction ***Accept (- 01/07/2025)***

Direct Care Staff did a deep clean in the kitchen on 10/4/2024 and 10//5/2025. Administrator will have training with all staff on Regulation: 2600.85.b. There may be no evidence of infestation of insects or rodents in the home on November 22.2024. Administrator or Designee will check during walk throughs daily beginning 10-4-2024 with documentation

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/01/2025)

85d - Trash Receptacles

9. 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

The trash can in the kitchen was uncovered.

Repeat Violation: 3/12/24, 2/1/24, 10/19/23 et al

Plan of Correction ***Accept (- 01/07/2025)***

On 10-4-2024 Administration verified that all bathrooms had trash cans with lids. Administrator will have training for all staff on Regulation 2600.85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents on Nov22,2024. Administration will due daily walk throughs beginning 111-22-2024 to confirm each bathroom and kitchen have lids on the trash cans.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/01/2025)

85e - Trash Outside Home

10. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

The right dumpster was full of trash and the right-side lid was not closed. There were multiple pieces of paper trash on the ground.

Plan of Correction ***Accept (- 01/07/2025)***

Administration closed on 10/3/2024 the lid on the outside dumpsters. A Sign was posted 10-4-2024 to remind the staff to shut the dumpster lid. A training on 11-22-2024 by administrator for all staff on 2600.85.e. Trash outside

85e - Trash Outside Home (continued)

the home shall be kept in covered receptacles that prevent the penetration of insects and rodents Designee will check dumpster lid durlng daily walk throughs beginning 11-22-2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/01/2025)

88a - Surfaces

11. 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

The double exit doors next to bedrooms #14 and #19 did not latch when closed. The doors stuck and could not be closed without exerting force.

The left side door of the double exit doors across from bedroom #25 did not latch when closed. The door latch at the top of the door did not operate.

The left side door of the double exit doors exiting to the smoking area did not latch when closed. The door latch at the top of the door was covered with black electric tape and did not operate.

Repeat Violation: 10/19/23 et al

Plan of Correction ***Directed (- 01/07/2025)***

Door by Rooms 14 & 19 had latch system loosened , on 11/15/24 by maintenance person. On 11/15, Administrator is ordering two new push bar handles. They arrived on 12/2/24 will be installed by maintenance man on 12/20/24. Administrator will do training with staff on Regulation 2600.88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards on Nov 22,2024.
Started building walk through daily by administrator or designee on 10/10/24.

Proposed Overall Completion Date: 12/13/2024

Directed:
By 1/15/25, the administrator will ensure the double exit doors next to bedrooms #14 and #19, the left side door of the double exit doors across from bedroom #25, and the left side door of the double exit doors exiting to the smoking area will be repaired. Documentation will be kept.
1/7/25

Directed Completion Date: *01/15/2025*

Not Implemented (- 02/01/2025)

89b - Hot Water Temperature

12. Requirements

89b - Hot Water Temperature *(continued)*

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At 11:10a.m., the hot water temperature in the bathroom shared by bedrooms #3 and #4 was 123.9 degrees Fahrenheit and at 2:55p.m. it was 122.1 degrees Fahrenheit.

Repeat Violation: 10/19/23 et al

Plan of Correction ***Accept (█ - 01/07/2025)***

Designee turned down water on hot water tank on 11/15/2024. Administrator will train a staff on Regulation 2600. 89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F. on Nov 22,2024. Designee will start checking water temps weekly starting on November 18,2024, moved to daily checks beginning 12-16-2024. Documentation kept at Facility

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

Implemented (█ - 02/01/2025)

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

The freezer handle was broken and detached from the bottom of the freezer in the kitchen's black refrigerator/freezer.

The home does not have an operable dishwasher. The dishwasher's bottom tray sprayer was disconnected and not operational.

Plan of Correction ***Accept (█ - 01/07/2025)***

On 10/4 DCS fixed the door handle on the kitchens black frig. Administrator assistant ordered the repair part for the dish washer, scheduled to arrive on Nov 19th. The part actually arrive Nov 30th, Admin assist installed. Dishwasher is still not working, will have new maintenance look to repair By Dec 30th. Administrator will hold training on November 22th with staff on regulation 2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards. 0n 10/10 Daily walk thru with Administrator or
Designee will help to bring all items to attention for further repairs.

Licensee's Proposed Overall Completion Date: *12/30/2024*

Not Implemented (█ - 02/01/2025)

101j2 - Bedroom Chairs

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

101j2 - Bedroom Chairs *(continued)*

Description of Violation

Bedroom #3 is occupied by 2 residents; however, there was only 1 chair in this room.

Plan of Correction ***Accept (- 01/07/2025)***

DCS put chairs in all rooms that have current residents to ensure every resident has a chair present as of 10/4/2024. Administrator is holding training with all staff on Nov 22,2024 on POC regulation 2600. 95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards. Administrator or Designee will do daily walk thu starting Nov 4,2024.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/01/2025)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

15. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

The grab bar next to the toilet was loose and the bottom pulled away from the wall approximately ½ to ¾ of an inch in the bathroom shared by bedrooms #16 and #17.

Plan of Correction ***Accept (- 01/07/2025)***

The grab bar was replaced by maintenance on 11-21-2024.
Administrator will do Staff training with all Staff on Nov 22, on Regulation: 2600. 102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces. Administrator or Designee will look for future issues during daily walk throughs beginning 11-23-2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/01/2025)

103e - Left Overs

16. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There were multiple unlabeled and undated items in the kitchen cabinet above the roaster to include: a plastic container of fruit loops cereal, a bag of flour/pancake mix, a bag of potato chips.

Repeat Violation: 3/12/24, 10/19/23 et al

103e - Left Overs *(continued)*

Plan of Correction ***Accept (█ - 01/07/2025)***

Administrator had all items disposed of that was not labeled or sealed on 10/4/2024. Administrator will hold staff training on Nov 22, 2024 with Staff on Regulation 103.g. Food shall be stored in closed or sealed container. Administrator or Designee will look for these items during daily walk throughs beginning 11-23-2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/01/2025)

103f - Refrigerator/Freezer Temps

17. Requirements

2600.
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

At 10:35a.m. the temperature in the freezer section of the black refrigerator/freezer was 5 degrees Fahrenheit and at 2:55p.m. it was 5 degrees Fahrenheit.

There were no thermometers in the 2 chest freezers in the dining area.

There was no thermometer in the brown chest freezer in the storage area.

Repeat Violation: 3/12/24, 10/19/23 et al

Plan of Correction ***Accept (█ - 01/07/2025)***

Administrator had new thermometers placed in the freezers on 10/4/24. New Kitchen person started keeping records of temps immediately. Administrator will hold training for all staff on Regulation 2600.103.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. on November 22,2024. Administrator or Designee are checking to verify temps are being checked daily beginning 11-23-2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/01/2025)

103g - Storing Food

18. Requirements

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

Description of Violation

There was an unsealed bag of tater tots and an unsealed bag of cheese sticks in the freezer section of the black refrigerator/freezer.

There were 4 unsealed bags of various uncooked pasta in the kitchen cabinet above the toasters.

There were multiple unsealed items in the kitchen cabinet above the roaster to include: a plastic container of fruit

103g - Storing Food (continued)

loops cereal, a bag of flour/pancake mix, two bags of cereal and a bag of potato chips.

Plan of Correction ***Accept (- 01/07/2025)***

Administrator had all open , unsealed containers of food disposed of 10/4, Administrator will hold training on 11/22 for all direct care staff on Regulation 2600 103.g. Food shall be stored in closed or sealed containers. Kitchen staff is monitoring daily also being checked during daily walk thru with Administrator or Designee beginning 11-23-2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/01/2025)

103j - Utensils Cleaning

19. Requirements

2600.
103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

Description of Violation

The home does not have an operable dishwasher. On 10/3/24, eating, drinking, and cooking utensils were manually washed and rinsed; however, they were not sanitized.

Plan of Correction ***Accept (- 01/07/2025)***

On 10/8 the home received sanitizing tablets to use in the wash cycle for dishes. Administrator to hold staff training with staff on Nov 22 on Regulation: 2600.
103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen). Daily starting 10/10 Administrator or Designee will monitor to ensure use of sanitizer during wash cycle. Working to get dishwasher fixed by 12/30.

Licensee's Proposed Overall Completion Date: *12/30/2024*

Not Implemented (- 02/01/2025)

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 10/3/24 the home served 22 residents, requiring 66 gallons of emergency drinking water. However, the home had only 53 gallons. The home did 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.

Repeat Violation: 10/19/23 et al

Plan of Correction ***Accept (- 01/07/2025)***

On 10-4-2024 the Regional Assistant ordered 20 gallons of water through the weekly food order to meet the

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

required water to have on hand. to be delivered by 10/10. A training by Administrator for all Staff on 11-22-2024 to include regulation 2600107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents. A weekly audit by Administrator or Designee to check the water supply will begin 11-25-2024 with documentation kept.
This is being disputed due to the fact that the Home has a contractural letter from the food company stating water and how much will be delivered immediately upon request in the event of an emergency.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/01/2025)

132a - Monthly Fire Drill

21. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held in 11/2023, 12/2023 or 9/2024.

Plan of Correction ***Accept (█ - 01/07/2025)***

On 10-16-2024 an unannounced fire drill was held by the Administrator. Also an unannounced one for November 16, 2024 was held. The Administrator or Designee will audit all fire drill regulations on the first day of each month beginning with December, 2024. They will determine the date for the next month and document all the drills as usual with a monthly report kept in the inspection book kept at Facility. A training by Administrator for all Staff on 11-22-2024 to include regulation 2600. 132.a. An unannounced fire drill shall be held at least once a month.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/01/2025)

132d - Evacuation

22. 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

During the months of March, 2024 and April, 2024, the home did not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

** 3/13/24 at 3:00 p.m. - 7 minutes, 25 seconds*
** 4/23/24 at 7:00 p.m. - 7 minutes, 45 seconds*

Repeat Violation: 3/12/24

132d - Evacuation *(continued)*

Plan of Correction ***Accept (█ - 12/06/2024)***

Administrator reviewed past fire drills on 10-4-2024. A training by Administrator for all Staff on 11-22-2024 to include regulation 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.The fire Safety expert will be due in May, 2025 and the Administrator has a reminder on the fire drill records. The current May, 2024 shows a time of 8 minutes 15 seconds to be followed.
This is being disputed as a Fire Safety Expert did a fire drill and inspection in May of 2024. Documentation at Facility

Licensee's Proposed Overall Completion Date: *11/25/2024*

Implemented (█ - 02/01/2025)

132g - Fire Drills Days/Times

23. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 1 staff person during the overnight shift, as evidenced on 9/15/24, 9/19/24 and 9/23/24. However, in the past year, the minimum number of staff participating in a sleeping time drill is 2.

Plan of Correction ***Accept (█ - 01/07/2025)***

A training by Administrator for all Staff on 11-22-2024 to include regulation 2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. The Administrator had a surprise fire drill on 11/25 at 10:30 pm with 1 staffer on duty. 20 residents evacuated at a time of 8 min and 11 seconds Documentation will be kept at Facility.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (█ - 02/01/2025)

141a 1-10 Medical Evaluation Information

24. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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 #1's initial medical evaluation, dated [redacted] does not indicate height, weight, pulse rate blood pressure and temperature. These sections of the form are blank.

Plan of Correction ***Accept ([redacted] - 12/06/2024)***

On 10-4-2024, Administrator had the required information added to the medical evaluation. All other medical evaluations will be reviewed by Administrator and Assistant beginning 11-25-2024. Monthly audits by Administrator or Assistant will be done beginning 12-1-2024. Documentation kept at Facility. A training by Administrator for all Staff held on 11-22-2024 to include regulation 2600.141.a2600. 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:
A general physical examination by a physician, physician's assistant or nurse practitioner.
Medical diagnosis including physical or mental disabilities of the resident, if any.
Medical information pertinent to diagnosis and treatment in case of an emergency.
Special health or dietary needs of the resident.
Allergies.
Immunization history.
Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
Body positioning and movement stimulation for residents, if appropriate.
Health status.
Mobility assessment, updated annually or at the Department's request.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 02/01/2025)

183b - Meds and Syringes Locked

25. 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.

183b - Meds and Syringes Locked *(continued)*

Description of Violation

There was an ampule of albuterol sulfate 0.083% - 2.5mg/3ml, unlocked, unattended and accessible, on resident #2's bedside table.

There was one 4-ounce tube of diaper rash paste and one 20-ounce tube of Desitin 40% paste, unlocked, unattended and accessible on the back of the toilet in the bathroom in bedroom #6.

There were 12 ampules of albuterol sulfate 0.083% - 2.5mg/3ml, unlocked, unattended and accessible on resident #3's bedside table.

Plan of Correction ***Accept (- 12/06/2024)***

On 10-3-2024 Administrator removed the medications that were in violation by not being locked up. Administrator did a walk through of the rest of the Home on 10-4-2024. A training by Administrator for all Staff on 11-22-2024 to review regulation 2600.183.b2600.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.walkthroughs by Administrator or Designee will be done daily beginning 11-25-2024 to check for any meds not in their right place. Documentation kept at facility.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented (- 02/01/2025)

183e - Storing Medications

26. 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 #7'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 #8's Insulin Lispro Syringe was not labeled with the date it was opened. The manufacturer's instructions indicate the medication expires 28 days after opening.

Plan of Correction ***Accept (- 12/06/2024)***

On 11-1-2024 the Assistant disposed of the undated items. Also on 11-1-2024 the Assistant checked all other medications in the building for proper marking and documentation. A training for all Staff by Administrator was done on 11-22-2024 to include regulation 2600.183.e183.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. Administrative Assistant will audit all meds weekly beginning 11-25-2024 to be sure compliance is met. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented (- 02/01/2025)

185a - Implement Storage Procedures

27. 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

Resident #1 is prescribed daily blood glucose checks. However, resident #1's glucometer readings were incorrectly documented on the September 2024 medication administration record (MAR) as follows:

Date:	Glucometer Reading:	September 2024 MAR:
9/8/24	160	Not documented
9/17/24	393	334
9/27/24	148	147
9/30/24	297	282

Resident #4 is prescribed daily morning blood glucose measurements. On 9/30/24, the resident's glucometer reading was 87; however, the resident's September MAR indicated a reading of 84.

Resident #5 is prescribed blood glucose checks 3 times daily. However, resident #5's glucometer readings were incorrectly documented on the September 2024 MAR as follows:

Date:	Time:	Glucometer Reading:	September 2024 MAR:
9/25/24	4:28 p.m.	112	123
9/26/24	11:13 a.m.	189	118
9/27/24	8:10 a.m.	112	114
9/30/24	5:21 p.m.	195	Not documented

Plan of Correction ***Accept (- 01/07/2025)***

A training by Administrator for All Staff was held on 11-22-2024 to review regulation2600. 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. The Med Techs have been trained by Administrator on 11-23-2024 to write all glucometer readings on a tablet on the med cart. On 11-1-2024 The Assistant reviewed all readings with what was documented to see where the errors occurred. A weekly audit beginning 11-25-2024 will be done by Assistant to verify the right readings are being documented.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/01/2025)

225a - Assessment 15 Days

28. 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 initial assessment, dated does not include the diagnosis of diabetes, as indicated on initial medical assessment, dated

225a - Assessment 15 Days (continued)

Repeat Violation: 10/19/23 et al

Plan of Correction ***Directed (- 01/07/2025)***

On 11-21-2024 Administrative Assistant resent Request to have DME updated to include the diagnosis of diabetes., all of residents records were updated 11/22/24. Beginning 11-25-24, Administrator or Designee will audit all other Assessments for accuracy on documentation on Assessments. Monthly audits by Administrator or Designee thereafter. On 11-22-2024 Administrator had a training for all Staff to include regulation 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. Documentation kept at Facility.

Proposed Overall Completion Date: 12/13/2024

Directed:

By 1/15/25, the administrator will update resident #1's assessment to include the diagnosis of diabetes.
1/7/25

Directed Completion Date: *01/15/2025*

Not Implemented (- 02/01/2025)

227a - Support Plan 30 Days

29. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #2 was admitted on ; however, the resident's initial support plan was not completed until

Plan of Correction ***Accept (- 12/06/2024)***

On 10-4-2024 Administrator and Designee audited all other Resident Support plans for accuracy on dates to be sure they were done in the required time frame. A list was composed by Administrator on 11-22-2024 indicating each Resident and their due dates for required forms. The form will note when each form was completed and when the next one is due, The list will be audited monthly by Administrator or Designee beginning 11-25-2024. Documentation kept at facility.A training for all Staff by Administrator on 11-22-2024 to include this regulation 2600.227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented (- 02/01/2025)

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

Facility Information

Name: *COUNTRY MANOR* **License #**: *44629* **License Expiration**: *12/11/2024*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRY MANOR PCH LP*
Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *Dept l & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *11/08/2024*

Inspection Dates and Department Representative

11/08/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *24*

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**: *13*
Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

11/08/2024 - Partial

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

Inspections / Reviews *(continued)*

12/27/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/13/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/03/2025*

01/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/06/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/15/2025*

02/24/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/14/2025*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 11/8/24 at 9:00 a.m., an agent of the Department requested the home's demographics and access to resident and staff files. However, staff person A was unable to provide information or grant access until 10:30 a.m., when the administrator arrived.

Plan of Correction ***Accept (- 12/27/2024)***

A training by Administrator for all staff is scheduled for 12-16-2024 on regulation 2600. 5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to: 1. Agents of the Department. Part of the training will be to not remove office key from med room keys. Staff person A did not have a key to the Office. Beginning 11-9-2024 Administrator or Designee will be sure a key to the office is available to the med tech at all times. Administrator or Designee will check med key ring for office key weekly with documentation

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented (- 02/01/2025)

16c - Written Incident Report

2. 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 11/6/24 at approximately 6:00 a.m., the home experienced a septic system malfunction, causing 18 toilets to overflow and rending them inoperable. The home activated its emergency preparedness plan by contacting a plumber as alternate means of meeting resident needs in the event of a utility outage. However, the home did not report this incident to the Department.

Repeat Violation 4/11/24

Plan of Correction ***Accept (- 12/27/2024)***

A training for all staff by Administrator is scheduled for 12-16-2024 to include regulation 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). The training also will include what items are considered reportable and what constitutes using the emergency operations plan.

This is being disputed due to the fact that this was not actually under what the home considers emergency operations. There was never a lack of anyone being able to use a toilet. There were 2 working toilets and portable commodes were available immediately with staff using sealable bags and cleaning after each use. No emergency personnel were ever called

Licensee's Proposed Overall Completion Date: *12/16/2024*

16c - Written Incident Report *(continued)*

Not Implemented (█ - 02/01/2025)

17 - Record Confidentiality

3. Requirements

2600.

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

Description of Violation

From 12:25 p.m. - 1:00 p.m., the medication room door was unlocked and the computer which contained electronic medication administration records for all residents, including resident #1, resident #2 and resident #3, was unlocked, unattended and accessible.

Plan of Correction ***Accept (█ - 01/07/2025)***

On 11-8-2024 Administrator locked the door and spoke with med techs about the importance of keeping it locked. A training on 12-16-2024 by Administrator for all staff on regulation 2600. 17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.
The training will include med techs being made aware that the Administrator or Designee will do daily random checks of the entire building to include the med room and if any resident records are not protected for privacy, they could be wrote up if it was their fault. Documentation kept at Facility

Proposed Overall Completion Date: 12/16/2024
Proposed Overall Completion Date: 01/03/2025

Licensee's Proposed Overall Completion Date: *01/03/2025*

Implemented (█ - 02/01/2025)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 11/6/24 at approximately 6:00 a.m., the home experienced a septic system malfunction, causing 18 toilets to overflow and rending them inoperable. On 11/7/24, the carpet in bedrooms #6, #7, #8, #9, #13, and #14 each contained a wet area approximately 5' x 7' that had a foul urine smell.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept (█ - 12/27/2024)***

On 11-6-2024, the day before State Inspectors came, the septic system malfunctioned for the majority of the building. The Housekeeper along With other staff cleaned the carpet in bedroom 6, 7, 8 , 9,13 and 14. They knew it would take several cleanings to correct it. 0n 11-8-2024 the Housekeeper re-cleaned the same areas. The areas will be checked by Administrator or Designee weekly beginning 12-16-2024 to check for wetness and odor. Documentation kept. If needed, they will clean again and if not improved, the carpet will need to be lifted and replaced. A training by Administrator for all staff is scheduled for 12-16-2024 to include regulation 2600. 85.a. Sanitary conditions shall be maintained.
This is being disputed due to proper procedures being followed immediately after overflow of toilets. It was understood that the areas would be cleaned several times due to the magnitude of the overflow. I don't know of any toilet in anybody's house that could overflow without any smell. The house keepers have cleaned the areas at least 3 times with the understanding if the areas stay wet or the smell does not go away, the carpet will be ripped up and replaced by maintenance. The foul smell was the day after the incident.

Licensee's Proposed Overall Completion Date: *12/16/2024*

Implemented (█ - 02/01/2025)

95 - Furniture and Equipment

6. Requirements

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

Description of Violation

On 11/6/24 at approximately 6:00 a.m., the home experienced a septic system malfunction, causing 18 toilets to overflow and rending them inoperable. On 11/8/24 at 9:45 a.m., the toilet in the shared bathroom of bedrooms #13 and #14 leaked at the base when flushed, causing a brown liquid to flow onto the floor in an approximate 1' diameter area.

Plan of Correction ***Directed (█ - 01/07/2025)***

On 11-6-2024, the day before State Inspectors came, the septic system malfunctioned for the majority of the building.Immediately The Housekeeper along With other staff cleaned the carpet in bathrooms of rooms 13 and 14. No commodes we're broken, just couldn't flush due to septic backup. They knew it would take several cleanings to correct it. 0n 11-8-2024 the Housekeeper re-cleaned the same areas. The areas will be checked by Administrator or Designee weekly beginning 12-16-2024 to check for wetness and odor. Documentation kept. If needed, they will clean again and if not improved, the carpet will need to be lifted and replaced. A training by Administrator for all staff is scheduled for 12-16-2024 to include regulation 2600. 95 Furniture and equipment-furniture and equipment must be in good repair, clean and free of hazards. Administrator or Designee will do daily monitoring of random toilets to be sure they are working
This is being disputed due to proper procedures being followed immediately after overflow of toilets. It was understood that the areas would be cleaned several times due to the magnitude of the overflow. I don't know of any toilet in anybody's house that could overflow without any smell or residual for a couple days. The house keepers have cleaned the areas at least 3 times with the understanding if the areas stay wet or the smell does not go away, the carpet will be ripped up and replaced by maintenance. The brown liquid was the day after the incident

Proposed Overall Completion Date: 01/06/2025

95 - Furniture and Equipment (continued)

Directed:

By 1/15/25, the administrator will ensure the toilet in the shared bathroom of bedrooms #13 and #14 is repaired and no longer leaking at the base when flushed, and the approximate 1' area of brown liquid on the floor will be cleaned and the floor will be sanitized. Documentation will be kept.

█ ***1/7/25***

Directed Completion Date: *01/15/2025*

Not Implemented (█ - 02/01/2025)

102a - Toilet - 6 users

7. Requirements

2600.
102.a. There shall be at least one functioning flush toilet for every six or fewer users, including residents, staff persons and household members.

Description of Violation

On 11/6/24 the home served 22 residents. On that date, there were 8 total staff in the home for a total of 30 users. The home had no functioning flush toilets at that time for a ratio of 0 toilets to 30 users.

On 11/7/24 the home served 22 residents. On that date, there were 8 total staff in the home for a total of 30 users. The home had no functioning flush toilets at that time for a ratio of 0 toilets to 30 users.

Plan of Correction ***Accept (█ - 01/07/2025)***

On 11-6-2024 immediately following overflow of toilets, staff utilized potty chairs that were in storage. No commodes were broken, just couldn’t flush due to septic backup. Administrator set up a system of lining the potty chairs with heavy plastic bags. After each resident was finished in bathroom, staff removed, sealed and disposed of bag in the trash. There was never a time that facilities were not available to resident. On 12-16-2024 A training by Administrator for all staff is scheduled to include regulation 2600. 102.a. There shall be at least one functioning flush toilet for every six or fewer users, including residents, staff persons and household members. Staff will also be informed of what is proper to flush down toilet. Administrator or Designee will do daily walkthroughs to check for working commodes.
This is being disputed due to the fact that there is no way to have stopped the overflow. Regularly scheduled. Septic service is done as required and needed. No person was without bathroom facilities.

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented (█ - 02/01/2025)

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

From 12:25 p.m. -1:00 p.m., the medication room door and medication carts were unlocked, unattended and accessible, causing all resident medications, to include medication belonging to resident #1, resident #2, and resident #3 to be accessible.

183b - Meds and Syringes Locked (continued)

Plan of Correction ***Accept (- 12/27/2024)***

On 11-8-2024 Administrator locked the med room door and spoke with med tech on duty about responsibilities concerning the keys. A training by Administrator for all staff on 12-16-2024 on regulation 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. Beginning 12-16-2024, Administrator or Designee will do random daily walkthroughs of the Home to be sure all medications and syringes are locked up. If the med door is locked, the Administrator may choose to write up the employee responsible. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: *12/16/2024*

Not Implemented (- 02/01/2025)

Facility Information

Name: *COUNTRY MANOR* **License #**: *44629* **License Expiration**: *12/11/2024*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRY MANOR PCH LP*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *25* **Waking Staff**: *19*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *11/20/2024*

Inspection Dates and Department Representative

11/20/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *24*

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**: *15*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

11/20/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/20/2024*

Inspections / Reviews *(continued)*

01/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/13/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/14/2025*

01/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/13/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/28/2025*

15c - Supervision

1. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On 11/13/24, at 9:00 a.m., the home was informed of an allegation of abuse involving staff person A and resident #1. The home allowed staff person A to work on 11/15/24, 11/16/24, 11/17/24 and 11/18/24 from [redacted] on a plan of supervision that was not submitted to, nor approved by, the Department.

Plan of Correction ***Accept (- 01/17/2025)***

Administrator Assist filed report with DHS on 11/14/2024. Staff A was immediately suspended when we found out who the claim was against. Administrator held POC training with staff on 11-14-24 regarding Regulation 2600.15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person. Administrator will monitor daily of any future incidents that occur and implement a checklist form of if a violation requires a person to be suspended or under supervision by Jan 3,2025 to use as a reference for all reporting needs in the future starting on 1-3-25.

Licensee's Proposed Overall Completion Date: *02/28/2025*

16c - Written Incident Report

2. 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 11/13/24, at 9:00 a.m., the home was informed of an allegation of abuse involving staff person A and resident #1. The home did not report this incident to the Department until 11/14/24 at 10:54 a.m.

Repeat Violation: 4/11/24 et al

Plan of Correction ***Accept (- 01/17/2025)***

The Administrator submitted report as soon as had information on dec14,2024. Administrator held POC training on dec 16,2024 with staff on Regulation 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).Administrator will use a incident reportable sheet by Jan 3,2025 to use as a reference for all reporting needs in the future. Administrator will monitor and document future incidents starting 1-1-25 daily to ensure all reportable incidents and conditions are being reported to the department within 24 hours of the occurrence of the incident.

Proposed Overall Completion Date: 02/28/2025

Licensee's Proposed Overall Completion Date: *02/28/2025*

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted], for resident #1 indicates the resident requires assistance with managing healthcare and medication administration. From 10/22/24 to 11/17/24, the resident was not administered prescribed Lithium 150mg, take twice a day, because the medication was not available in the home. Resident #1 had to contact the prescriber [redacted] to get the medication; and therefore, did not receive this assistance as required.

Repeat Violation: 2/1/24

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

Administrator contacted Pharmacy on 11-18-24 when brought to [redacted] attention and Medication was delivered that evening from the Pharmacy. Administrator held POC training with staff on 12/16/24 Regulation 2600.23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan. All new patient meds will be checked by Administrator, Med Tech, or Administrator Assistant when a new admission arrives starting 1-1-25. Starting 1-1-25 all med techs have been trained on the new policy designed by Administrator, and Administrator Assistant on a list to reorder medications for residents and to make sure medications are being delivered in a timely manner. Resident medication re-ordering list when re-ordering medications will be created by 1-1-25 and given to Administrator or Designee to contact Pharmacy or Doctor immediately if any medication is missing or needs a refill. Follow ups on this re-ordering medication will be done for all Med-tech shift changes starting on 1-1-25, and documentation on when medication is delivered or still needed will be kept at facility. Starting December 18th routine med audits are being done by Med Techs, Administrator, and Administrator Assistant 3 times a week, to ensure we are not missing any medications.

We are disputing violation 2600.23a A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan due to resident 1 did not have a valid order for [redacted] medication to be administered or delivered to the facility from dates 10/22/24-11/14/24. In resident 1's medication order sheet the medication referred to in this violation was started on 10/21/24 and stopped on 10/22/24. Resident 1 was admitted to the facility on [redacted]. Resident 1 obtained a new order for said medication on this violation on 11/14/24. Once Administrator was made aware on 11-18-2024 that the medication was in the MAR however not at the facility Administrator contacted the pharmacy as to where the pharmacy delivered the medication for resident 1 that evening. Resident was discharged to [redacted] on [redacted] All documentation is kept at facility.

Licensee's Proposed Overall Completion Date: *02/28/2025*

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b - Abuse *(continued)*

Description of Violation

Resident #1 was admitted to the home on [redacted] with diagnoses of schizoaffective disorder bipolar type, generalized anxiety disorder, hyperlipidemia, history of back pain, Insulin-dependent diabetes mellitus, chronic obstructive pulmonary disease, hypertension, and vitamin D deficiency. Resident #1's assessment and support plan, dated [redacted], indicated that the home's direct care staff will assist the resident with managing health care and administering medications. The resident was prescribed Lithium 150 mg, take twice a day. However, resident #1 was not administered the prescribed Lithium from 10/22/24 to 11/17/24 because the medication was not available in the home. The resident indicated [redacted] went through severe withdrawal and felt like [redacted] was going to die. The resident had to call the physician [redacted] to have the medication ordered for the home.

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

Administrator contacted Pharmacy on 11-18-24 when brought to [redacted] attention and Medication was delivered that evening from the Pharmacy. Administrator held POC training with staff on 12/16/24 Regulation 2600.42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. All new patient meds will be checked by Administrator, Med Tech, or Administrator Assistant when a new admission arrives starting 1-1-25. Starting 1-1-25 all med techs have been trained on the new policy, as of 12-30-2024, designed by Administrator, and Administrator Assistant on a list to reorder medications for residents and to make sure medications are being delivered in a timely manner. Resident medication re-ordering list when re-ordering medications will be created by 1-1-25 and given to Administrator or Designee to contact Pharmacy or Doctor immediately if any medication is missing or needs a refill. Follow ups on this re-ordering medication will be done for all Med-tech shift changes starting on 1-1-25, and documentation on when medication is delivered or still needed will be kept at facility. Starting December 18th routine med audits are being done by Med Techs, Administrator, and Administrator Assistant 3 times a week, to ensure we are not missing any medications.

We are disputing violation 2600.23a A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan due to resident 1 did not have a valid order for [redacted] medication to be administered or delivered to the facility from dates 10/22/24-11/14/24. In resident 1's medication order sheet the medication referred to in this violation was started on 10/21/24 and stopped on 10/22/24. Resident 1 was admitted to the facility on [redacted] Resident 1 obtained a new order for said medication on this violation on 11/14/24. Once Administrator was made aware on 11-18-2024 that the medication was in the MAR however not at the facility Administrator contacted the pharmacy as to where the pharmacy delivered the medication for resident 1 that evening. Resident was discharged to [redacted] on [redacted] All documentation is kept at facility. Proposed Overall Completion Date: 02/28/2025

Licensee's Proposed Overall Completion Date: *02/28/2025*

42c - Treatment of Residents

5. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

42c - Treatment of Residents *(continued)*

Description of Violation

Multiple residents have indicated that staff person A has yelled, screamed, and swore at them. They indicated that staff person A is "horrible, nasty," and they feel targeted by [redacted]

Repeat Violation: 4/11/24 et al

Plan of Correction ***Directed ([redacted] - 01/17/2025)***

Staff A was suspended on [redacted], and put on Supervision on [redacted] upon [redacted] return to the assigned shift. Administrator held a staff meeting for all staff on 11-14-2024 going over resident rights. Administrator held POC training 12/16/24 with staff on Regulation 2600.42.c. A resident shall be treated with dignity and respect. Administrator is working to move Staff A out of Med Room, [redacted] feels anxiety when in there. Staff A currently is still being supervised when working in the med room, which went from 4-5 days a week to 1-2 days a week. Staff A will be under supervision during [redacted] shifts in the med room until [redacted] is completely removed from the med room.
Administration will find and/or schedule a course for all staff to take on treatment of Residents by January 20th 2025.
Administrator and Administrative Assistant will randomly interview 3 residents a week for 1 month and monthly after to determine if residents are being treated with dignity and respect starting on January 13th, 2025.
Documentation will be kept at facility.

Directed Completion Date: *02/28/2025*

187d - Follow Prescriber's Orders

6. Requirements

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

Description of Violation

Resident #1 was prescribed Lithium 150mg, take twice a day. However, resident #1 was not administered this medication from 10/22/24 to 11/17/24 because it was not available in the home.

Resident #1 was prescribed Lantus Solostar 100 units/ml, inject subcutaneous 35 units in the morning, and 25 units at bedtime. However, resident #1 was not administered this medication from 10/22/24 to 10/30/24.

Repeat Violation: 3/12/24, 12/21/23, 10/19/23 et al 8/31/23

Plan of Correction ***Directed ([redacted] - 01/17/2025)***

Administrator held POC training with staff 12/16/24 on Regulation2600.187.d. The home shall follow the directions of the prescriber.. Med Techs were trained to use paper Mars if this happens in the future. Designee will be doing Audits three times a Week starting Dec 18th 2024. All New Residents Mars will be verified by Designee upon admission, and ongoing during each med audit when as needed. When items do not match, written protocol will be posted to follow in Med Room by Jan 3, 2025

187d - Follow Prescriber's Orders (continued)

Proposed Overall Completion Date: 02/28/2025

Directed:
By 2/28/25, the administrator will develop and implement policy and procedures to ensure all prescribed resident medication is available in the home at all times. All staff will be trained on new policy and procedures. Documentation will be kept.
█ ***1/17/25***

Directed Completion Date: *02/28/2025*

Facility Information

Name: *COUNTRY MANOR* **License #**: *44629* **License Expiration**: *12/11/2024*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRY MANOR PCH LP*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *23* **Waking Staff**: *17*

Inspection Information

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

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

Inspection Dates and Department Representative

12/04/2024 - On-Site:

12/05/2024 - Off-Site:

12/09/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *22*

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**: *14*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

12/04/2024 - Partial

Lead Inspector: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/15/2025*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1, admitted to the home on [redacted], has diagnoses of non-insulin dependent diabetes mellitus, heart failure, benign prostatic hyperplasia, hypertension, and pain. The resident has a history of cellulitis of the left foot, and ulcer wound on the right foot. The assessment and support plan, dated [redacted], for resident #1 indicates the resident requires assistance with personal hygiene and managing and securing health care. However, according to the resident, [redacted] has not showered in 3 weeks, and according to staff, [redacted] has not showered in 2 months. When the resident removed [redacted] slippers there was a permeating odor of rotting flesh. Resident #1's left foot was swollen, discolored and the skin was flaky. The toenails were yellow, thick and long, lifting off the nail bed. There was an approximate dime-sized skin wound on the inside ankle, and an approximate 2-inch laceration on the inside/bottom of foot. The resident has not received assistance with hygiene, and managing and securing health care. In addition, resident #1 has an order for Triple Antibiotic Ointment to be applied topically to ulcer on right foot every day and covered with a dry sterile dressing until healed. The resident has not been administered this ointment for over a month, and staff could not indicate whether or not this ulcer has healed.

Resident #2, admitted to the home on [redacted] has diagnoses of diabetes mellitus, major depression moderate, stroke, and obstructive sleep apnea. The resident has a history of falls resulting in injuries, and chronic calculous cholecystitis. The assessment and support plan, dated [redacted] for resident #2 indicates the resident requires assistance with securing health care and making and keeping appointments. On [redacted], resident #2 fractured [redacted] right ankle. Surgery was scheduled on 6/27/24; however, this appointment was not kept, and the resident did not receive the surgery. The resident was to be evaluated for a bone fusion surgery; however, this appointment has not been made for the resident. Resident #2 indicated [redacted] is in constant pain, and staff have observed the resident in the past week sitting in the dining room crying because [redacted] is in so much pain. The resident did not receive assistance with securing health care and making and keeping appointments as required.

Repeat Violation: 2/1/24

Plan of Correction ***Directed ([redacted] - 01/10/2025)***

By 1/13/25, the administrator will contact resident #1 and resident #2's physicians and designees to report their current health status. All prescriber's directions will be followed. Documentation will be kept.

By 2/15/25 and monthly thereafter, the administrator will meet with all direct care staff and review the needs of each resident for whom the staff provides direct care, as indicated in the RASP, to ensure all resident's needs are met, and will review prescriber's directions to ensure all resident medication is present in the home and administered in accordance with the prescriber's directions. Reviews will be done with all new hires prior to performing direct care, and all direct care staff within 24 hours of any significant change RASPs. Documentation of reviews will be kept.

23a - Activities of Daily Living Assistance (continued)

By 2/15/25, the administrator will develop and implement policy and procedures to ensure all residents receive proper medical care in a timely manner. The policy and procedures will include seeking proper medical care through the resident's physician or emergency medical care, recognition and response to emergency situations and a decline in the resident's health status, proper notification to the resident's physician, designee, and the home's administrator or designated staff person when a resident's health status declines, scheduling and ensuring the resident keeps medical appointments and rescheduling any missed medical appointments. All staff persons will be educated on the policy and procedures to ensure all residents receive proper medical care. Documentation will be kept.

By 2/15/25, weekly for 1 month, and monthly thereafter, the administrator will privately interview 3 residents to ensure their needs are being met in accordance with their RASP, to determine if their needs have changed, and to ensure medication is being administered in accordance with prescriber's directions. Any significant changes will be documented on the resident RASP within 5 days. Documentation will be kept.

Directed Completion Date: *02/15/2025* ***Not Implemented (- 02/18/2025)***

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1, admitted to the home on has diagnoses of non-insulin dependent diabetes mellitus, heart failure, benign prostatic hyperplasia, hypertension, and pain. The resident has a history of cellulitis of the left foot, and ulcer wound on the right foot. The assessment and support plan, dated for resident #1 indicates the resident requires assistance with personal hygiene and managing and securing health care. However, according to the resident, has not showered in 3 weeks, and according to staff, has not showered in 2 months. When the resident removed slippers there was a permeating odor of rotting flesh. Resident #1's left foot was swollen, discolored and the skin was flaky. The toenails were yellow, thick and long, lifting off the nail bed. There was an approximate dime-sized skin wound on the inside ankle, and an approximate 2-inch laceration on the inside/bottom of foot. The resident has not received assistance with hygiene, and managing and securing health care. In addition, resident #1 has an order for Triple Antibiotic Ointment to be applied topically to ulcer on right foot every day and covered with a dry sterile dressing until healed. The resident has not been administered this ointment for over a month, and staff could not indicate whether or not this ulcer has healed.

Resident #2, admitted to the home on has diagnoses of diabetes mellitus, major depression moderate, stroke, and obstructive sleep apnea. The resident has a history of falls resulting in injuries, and chronic calculous cholecystitis. The assessment and support plan, dated for resident #2 indicates the resident requires assistance with securing health care and making and keeping appointments. On , resident #2 fractured right ankle. Surgery was scheduled on 6/27/24; however, this appointment was not kept, and the resident did not receive the surgery. The resident was to be evaluated for a bone fusion surgery; however, this appointment has not been made for the resident. Resident #2 indicated is in constant pain, and staff have observed the resident in the past week sitting in the dining room crying because is in so much pain.

Plan of Correction ***Directed (- 01/10/2025)***

By 1/13/25, the administrator will contact resident #1 and resident #2's physicians and designees to report their

42b - Abuse (continued)

current health status. All prescriber's directions will be followed. Documentation will be kept.

By 2/15/25 and monthly thereafter, the administrator will meet with all direct care staff and review the needs of each resident for whom the staff provides direct care, as indicated in the RASP, to ensure all resident's needs are met, and will review prescriber's directions to ensure all resident medication is present in the home and administered in accordance with the prescriber's directions. Reviews shall be done with all new hires prior to performing direct care, and all direct care staff within 24 hours of any significant change RASPs. Documentation of reviews will be kept.

By 2/15/25, the administrator will develop and implement policy and procedures to ensure all residents receive proper medical care in a timely manner. The policy and procedures will include seeking proper medical care through the resident's physician or emergency medical care, recognition and response to emergency situations and a decline in the resident's health status, proper notification to the resident's physician, designee, and the home's administrator or designated staff person when a resident's health status declines, scheduling and ensuring the resident keeps medical appointments and rescheduling any missed medical appointments. All staff persons will be educated on the policy and procedures to ensure all residents receive proper medical care. Documentation will be kept.

By 2/15/25, weekly for 1 month, and monthly thereafter, the administrator will privately interview 3 residents to ensure their needs are being met in accordance with their RASP, to determine if their needs have changed, and to ensure medication is being administered in accordance with the prescriber's directions. Any significant changes will be documented on the resident RASP within 5 days. Documentation will be kept.

Directed Completion Date: *02/15/2025* ***Not Implemented (- 02/18/2025)***

51 - Criminal Background Check

3. Requirements

2600.

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

Description of Violation

Staff person A, hired has not had a criminal background checked completed.

Repeat Violation: 4/11/24 et al, 3/12/24, 10/19/23 et al

Plan of Correction ***Directed (- 01/10/2025)***

By 1/13/25, the administrator will obtain a Pennsylvania State Police Criminal Background Check for staff person A. Documentation will be kept.

By 2/15/25 and weekly thereafter, the administrator will audit all employee files to ensure a Pennsylvania State Police Criminal Background Check is present. Documentation will be kept.

Directed Completion Date: *02/15/2025* ***Not Implemented (- 02/18/2025)***

58a - Awake Staff 16 or More

4. Requirements

2600.

58a - Awake Staff 16 or More *(continued)*

58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

On 11/24/24, 20 residents were present in the home. Two direct care staff persons were on duty; however, staff person B was asleep on the sofa in the TV room from approximately [redacted] In addition, multiple resident and staff interviews indicated they observed staff person B sleeping on several occasions in the past weeks in the home.

Plan of Correction ***Directed ([redacted] - 01/10/2025)***

By 1/15/25 and weekly thereafter, the administrator or designee will make an unannounced visit to the home during the overnight shift to ensure all scheduled staff are present and awake. Documentation will be kept.

By 2/15/25, the administrator will reeducate all staff regarding the requirement that if a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home. Documentation will be kept.

Directed Completion Date: *02/15/2025*

Implemented ([redacted] - 02/18/2025)

142a - Secure Medical Care

5. Requirements

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

On [redacted] resident #2 fractured [redacted] right ankle. The resident did not go to the scheduled surgery on 6/27/24 nor was an appointment made for a bone fusion evaluation. The home has not assisted the resident in making/keeping these appointments, resulting in constant pain for the resident.

Plan of Correction ***Directed ([redacted] - 01/10/2025)***

By 1/13/25, the administrator will contact resident #2's physician and designee to report their current health status. All prescriber's directions will be followed. Documentation will be kept.

By 2/15/25, the administrator will develop and implement policy and procedures to ensure all residents receive proper medical care in a timely manner. The policy and procedures will include seeking proper medical care through the resident's physician or emergency medical care, recognition and response to emergency situations and a decline in the resident's health status, proper notification to the resident's physician, designee, and the home's administrator or designated staff person when a resident's health status declines, scheduling and ensuring the resident keeps medical appointments and rescheduling any missed medical appointments. All staff persons will be educated on the policy and procedures to ensure all residents receive proper medical care. Documentation will be kept.

By 2/15/25, weekly for 1 month, and monthly thereafter, the administrator will privately interview 3 residents to ensure their needs are being met in accordance with their RASP, to determine if their needs have changed, and to ensure medication is being administered in accordance with the prescriber's directions. Any significant changes will

142a - Secure Medical Care (continued)

be documented on the resident RASP within 5 days. Documentation will be kept.

Directed Completion Date: *02/15/2025* ***Not Implemented (- 02/18/2025)***

187b - Date/Time of Medication Admin.

6. 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 #1's November 2024 & December 2024 medication administration record (MAR) was initialed by staff person on the following dates at 8:30 a.m. as administering Triple Antibiotic Ointment once daily: 11/2/24, 11/3/24, 11/4/24, 11/5/24, 11/8/24, 11/11/24, 11/12/24, 11/13/24, 11/14/24, 11/20/24, 11/21/24/, 11/22/24, 11/23/24, 11/26/24, 11/27/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, and 12/4/24. However, this medication was not administered to the resident.

Repeat Violation: 4/11/24 et al, 10/19/23 et al

Plan of Correction ***Directed (- 01/10/2025)***

By 1/15/25, weekly for 2 months, and monthly thereafter, the administrator will observe all staff qualified to administer medication perform a medication pass. Observations will include comparing medications administered to the resident MAR to ensure all resident medications are administered and documented according to the directions of the prescriber. Documentation will be kept.

By 2/15/25, the administrator will reeducate all staff qualified to administer medication regarding the requirement that medication administration shall be recorded at the time the medication is administered, by the person administering the medication. Documentation will be kept.

By 2/15/25 and monthly thereafter, the administrator or designated staff person qualified to administer medication will conduct an audit of all physician directions and resident MARs to ensure all prescribed medications are present in the home, indicated on resident MARs, administered in accordance with the prescriber's directions and administration is properly documented on the resident MAR. Documentation will be kept.

Directed Completion Date: *02/15/2025* ***Not Implemented (- 02/18/2025)***

187c - Refusal of Medication

7. 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 #1 is ordered a blood glucose check every day. On the following dates at 8:00 a.m., the resident refused the blood glucose checks: 11/2/24, 11/3/24, 11/4/24, 11/5/24, 11/6/24, 11/7/24, 11/8/24, 11/12/24, 11/13/24, 11/6/24, 11/19/24, 11/21/24, 11/22/24, 11/26/24-11/28/24, 12/1/24, and 12/2/24. However, the home did not report these refusals to the prescriber.

187c - Refusal of Medication *(continued)*

Plan of Correction ***Directed (█ - 01/10/2025)***

By 1/13/25, the administrator will contact resident #1's physician and report medication refusals. Documentation will be kept.

By 2/15/25, all staff will be reeducated regarding the requirement that 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. Documentation will be kept.

By 2/15/25 and monthly thereafter, the administrator or designated staff person qualified to administer medication, will audit resident MARs to ensure all resident medication refusals are documented accurately and the prescriber has been notified. Documentation will be kept.

Directed Completion Date: *02/15/2025* ***Not Implemented (█ - 02/18/2025)***

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident #1 is prescribed Triple Antibiotic Ointment, apply topically to ulcer on right foot every day; cover with dry sterile dressing until healed. However, according to staff, the resident was not administered this medication for over a month.

Repeat Violation: 3/12/24 & 12/21/23, 10/19/23 et al

Plan of Correction ***Directed (█ - 01/10/2025)***

By 1/15/25, weekly for 2 months, and monthly thereafter, the administrator will observe all staff qualified to administer medication perform a medication pass. Observations will include comparing medications administered to the resident MAR to ensure all resident medications are administered and documented according to the directions of the prescriber. Documentation will be kept.

By 2/15/25, the administrator will reeducate all staff qualified to administer medication regarding the requirement that the home shall follow the directions of the prescriber. Documentation will be kept.

By 2/15/25 and monthly thereafter, the administrator or designated staff person qualified to administer medication will conduct an audit of all physician directions and resident MARs to ensure all prescribed medications are present in the home, indicated on resident MARs, administered in accordance with the prescriber's directions and administration is properly documented on the resident MAR. Documentation will be kept.

187d - Follow Prescriber's Orders *(continued)*

Directed Completion Date: *02/15/2025* ***Not Implemented (- 02/18/2025)***

225c - Additional Assessment

9. Requirements .

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1 was admitted to the home on The home has been documenting behaviors for the resident from to present to include: yelling, screaming and threatening to punch other residents in the face, telling staff that and other residents want to kill the staff, calling multiple residents derogatory/offensive names, not showering for weeks/months. However, resident #1's assessment, dated has not been updated to include these behaviors.

Repeat Violation: 10/19/23 et al

Plan of Correction ***Directed (- 01/10/2025)***

By 1/13/25, the administrator will contact resident #1's physician and designee to report their current health status. All prescriber's directions will be followed. Documentation will be kept.

By 1/15/25, the administrator will update resident #1's RASP.

By 2/15/25 and monthly thereafter, the administrator or designee will audit all resident RASPs for accuracy, to include any changes in the resident's health or behaviors, and timeliness. Documentation will be kept.

Directed Completion Date: *02/15/2025* ***Not Implemented (- 02/18/2025)***