pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SUNRISE PERSONAL CARE HOME LLC**
LEGAL ENTITY

To operate **SILVER SPRING PERSONAL CARE HOME**
NAME OF FACILITY OR AGENCY

Located at **125 STATE ROAD, MECHANICSBURG, PA 17055**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **64**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **March 13, 2025** until **March 13, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338670**

ISSUING OFFICER

DEPUTY SECRETARY

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

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: MARCH 13, 2025

[redacted]
Sunrise Personal Care Home LLC
[redacted]

RE: Silver Spring Personal Care Home
125 State Road
Mechanicsburg, Pennsylvania 17055
License #: 33867

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 13th 2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-Term Living

Enclosure
<Licensing Inspection Summaries>

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

March 13, 2025

[redacted]
SUNRISE PERSONAL CARE HOME LLC
[redacted]

RE: SILVER SPRING PERSONAL CARE HOME
125 STATE ROAD
MECHANICSBURG, PA, 17055
LICENSE/COC#: 33867

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/15/2025, 01/16/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SILVER SPRING PERSONAL CARE HOME* **License #**: *33867* **License Expiration**: *03/10/2025*

Address: *125 STATE ROAD, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

Name: [redacted]

Legal Entity

Name: *SUNRISE PERSONAL CARE HOME LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/20/2022* **Issued By**: *Silver Spring Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date**: *01/16/2025*

Inspection Dates and Department Representative

01/15/2025 - On-Site: [redacted]

01/16/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *48*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

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

Have Mobility Need: *23* **Have Physical Disability**: *2*

Inspections / Reviews

01/15/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/08/2025*

02/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/12/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/12/2025*

Inspections / Reviews *(continued)*

03/13/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/12/2025*

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

132e - Fire Drill Sleeping Hours

1. Requirements

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

Description of Violation

The last fire drill conducted during sleeping hours was on 11/15/2024. The previous sleeping hours fire drill was conducted on 05/03/2024. This would be 6 months and 12 days apart.

Repeated Violation - 04/01/2024, et al

Plan of Correction ***Accept[redacted] - 02/10/2025)***

Immediate Corrective Action:
On 1/15/2025 the Administrator was educated by the on-site department representatives regarding the guidelines for interpretation of the fire drill during sleeping hours once every 6 months.
On 1/16/2025 the Administrator educated the Maintenance Director on the regulation that when the fire drill is held during sleeping hours once every 6 months it must occur no more than 6 months apart, based on the day of the month the drill took place (not just the month in which it occurs).

Plan for Ongoing Compliance:
On 2/10/2025 the Administrator will update the home's fire drill policy to include specific directions relating to the timing of the fire drill held during sleeping hours once every 6 months.
On 2/10/2025 the Maintenance Director will begin a weekly audit of the fire drill logs to determine when the next fire drill should be held to remain fully compliant with the regulation.

Proposed Overall Completion Date: 03/10/2025

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented[redacted] 03/13/2025)

184a - Resident's Meds Labeled

2. Requirements

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

Description of Violation

*Resident 1 has a current order for Diclofenac 1% gel with orders to "apply topically 3 times daily as needed for pain *use provided dosing cards*". However, the pharmacy label on this medication has the prior order for this medication, which states, "apply 2 grams topically to affected area 4 times daily (Pain)*use provided dosing cards*". This order was discontinued on 01/02/2025.*

Plan of Correction ***Accept[redacted] - 02/10/2025)***

Immediate Corrective Action:

184a - Resident's Meds Labeled (continued)

On 1/16/2025, as soon as the mis-labeled medication was identified, the Medication Technician placed a change of direction sticker on the medication and labeled it correctly with the prescribed dosage and instructions for administration.

Plan for Ongoing Compliance:
On 2/3/2025 the Wellness Director began conducting weekly audits of all medication carts to ensure that the original container for prescription medications is labeled with a pharmacy label that includes the prescribed dosage and instructions for administration.
On 2/10/2025 the Wellness Director will begin training the nurses and medication technicians on how to audit the medication carts to ensure the original container for prescription medications is labeled with a pharmacy label that includes the prescribed dosage and instructions for administration.
On 2/19/2025 The Wellness Director will educate all nurses and medication technicians on the regulation that the original container for prescription medications shall be labeled with a pharmacy label that includes the prescribed dosage and instructions for administration.

Proposed Overall Completion Date: 03/10/2025

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented [redacted] - 03/13/2025)

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

March 13, 2025

[redacted]
SUNRISE PERSONAL CARE HOME LLC
[redacted]

RE: SILVER SPRING PERSONAL CARE HOME
125 STATE ROAD
MECHANICSBURG, PA, 17055
LICENSE/COC#: 33867

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/21/2024, 11/22/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SILVER SPRING PERSONAL CARE HOME* **License #**: *33867* **License Expiration**: *03/10/2025*

Address: *125 STATE ROAD, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

Name: [redacted]

Legal Entity

Name: *SUNRISE PERSONAL CARE HOME LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/20/2022* **Issued By**: *Silver Spring Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

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

Inspection Dates and Department Representative

11/21/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *47*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

Have Mobility Need: *21* **Have Physical Disability**: *4*

Inspections / Reviews

11/21/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/21/2024*

12/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/03/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/06/2025*

Inspections / Reviews *(continued)*

01/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/03/2025*

03/13/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/03/2025*

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

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 11/21/2024 at approximately 10:30AM, the following documents were requested:

- *Incident reporting policy. This was requested again 11/21/2024 at 1:30PM and was not received until 11/21/2024 at 3:00PM.*
- *Quality Assurance policy & review. The verification of Quality Management review not received until 11/22/2024.*
- *Smoking policy. This was requested again 11/21/2024 at 1:30PM. However, no documentation was provided to indicate that staff may smoke in a designated area "by the shed".*
- *The "policies" binder was provided at 2:00PM on 11/21/2024.*

On 11/21/2024 at approximately 10:45AM, the following documents were requested:

- *Resident 1's financial records. Copies of statements signed by Resident were received on 11/22/2024 at 9:15AM.*
- *Discharge record and verification of refund for Resident 2. This was requested again on 11/22/2024 at 9:15AM. Documents were not provided.*
- *Resident records. 2 resident records were received at 11:30AM on 11/21/2024. However, the remaining 4 resident records requested were not received until 1:30PM on 11/21/2024.*

On 11/22/2024 at approximately 9:30AM, signed resident photo release forms were requested. At that time, a blank release form was provided. Signed resident photo release forms were requested a 2nd time. However, signed resident photo release forms were not provided until 5:42PM on 11/22/2024.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

***Immediate Corrective Action**:*

On 11/21/2024 the existing policy and procedure binder was submitted to the site inspectors for review.
On 11/21/2024 the Business Office Manager requested the discharge record and verification of refund for Resident #2 from the accounting department.
On 11/22/2024 the Business Office Manager accessed each resident electronic medical record and printed the signed photo release form. The Administrator then submitted all signed photo release forms to the lead inspector via email.

Plan for Ongoing Compliance:

On 11/25/2024 the Administrator began updating inaccurate or missing policies from the current policy and procedure binder. Revised policies included incident reporting, quality assurance, smoking, financial records, and discharge records.
On 11/26/2024 the Business Office Manager began auditing all resident financial records to ensure each resident's quarterly statement was signed. Financial records will be maintained in a separate binder in the Business Office for easy reference.
On 11/26/2024 the Business Office Manager received the requested discharge record and verification of refund for Resident #2 from the accounting department. This documentation was added to the electronic medical record for Resident #2.

5a1 - DHS Access (continued)

On 12/2/2024 the Business Office Manager was educated on the regulations relating to financial records of each resident.
On 12/5/2024 the Administrator educated the Business Office Manager and Wellness Director on the importance of timely access to all resident records when requested by agents of the department.
Beginning on 12/23/2024 the Community Relations Manager will place a copy of new resident Photo Release forms in a binder for easy reference.
Beginning on 1/6/2025 the Administrator will utilize the Personal Care Home Provider Entrance Conference Guide to create a binder that contains all documents necessary to ensure that the home can provide immediate access to items requested for review by the Department. This binder will be reviewed on a monthly basis and updated as necessary.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

15a - Resident Abuse Report

2. Requirements

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

Description of Violation

On [redacted]6/2024, at 5:28AM, Resident 3 pushed their call bell for assistance to go to the bathroom. Staff Person A responded to the call bell. When Resident 3 requested assistance to the bathroom, Staff Person A refused to assist Resident 3 and instructed the resident to [redacted]in your pants" and then Staff Person A would change Resident 3 in their bed. Resident 3 refused to urinate in [redacted]briefs and asked Staff Person A again to use the toilet. Staff Person A again refused to provide assistance to the bathroom and left the resident's room. At 6:45AM, Resident 3 pushed [redacted] call bell again and another staff person assisted Resident 3 to the bathroom. Resident 3 was frustrated and voiced anger in having to hold [redacted]bladder for over an hour and told to urinate[redacted]. Staff Person A was [redacted] as a result of this action. However, this allegation was never reported to the Local Area Agency on Aging.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/6/2024 the Wellness Director and Human Resources Manager conducted an investigation into the allegations against Staff Member A. Based on this investigation, Staff Member A was terminated on 11/6/2024.
On 1/7/2025 the Administrator will report the incident to the local Area Agency on Aging.

Plan for Ongoing Compliance:
On 11/29/2024 the Administrator was educated on reporting procedures in accordance with the Older Adult Protective Services Act (relating to reporting suspected abuse).
On 12/13/2024 the Administrator reviewed the Suspected Resident Abuse Reporting and Investigation Requirements in the Regulatory Compliance Guide to ensure compliance in the future.
On 12/27/2024 the Administrator will educate the Wellness Director and Wellness Coordinator on abuse allegations and reporting procedures to ensure all incidents are reported in a timely manner.

15a - Resident Abuse Report (continued)

On 1/6/2025 the Administrator will begin a daily review of all incidents and resident notes in the electronic medical record to ensure all abuse allegations are being reported within the required time frame.
On 1/23/2025 the Administrator and Wellness Director will educate all staff members on how to identify abuse and the requirements of reporting abuse.

Proposed Overall Completion Date: 01/23/2025

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented [redacted] - 03/13/2025)

28e - Death of a Resident

3. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident 2 [redacted] away on [redacted]. The home did not provide verification of a refund in accordance with the Elder Care Payment Restitution Act (35 P.S. § 10226.101 – 10226.107).

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/21/2024 the Business Office Manager requested the discharge record and verification of refund for Resident #2 from the accounting department.

Plan for Ongoing Compliance:
On 11/26/2024 the Business Office Manager received the requested discharge record and verification of refund for Resident #2 from the accounting department. This documentation was added to the electronic medical record for Resident #2.
On 12/2/2024 the Business Office Manager was educated on the regulations relating to financial records of each resident.
On 12/10/2024 the Business Office Manager conducted an audit of deceased residents' records to ensure a record of the refund is placed in the resident's electronic medical record.
On 1/13/2025 the Business Office Manager will begin auditing all deceased resident records to ensure on-going compliance with regulations relating to financial records of each resident. The initial audit of financial records will be completed by 1/31/2025 and will be conducted on a quarterly basis with subsequent deadlines of 4/30/2025, 7/31/2025, and 10/31/2025.

Proposed Overall Completion Date: 10/31/2025
Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

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.

Description of Violation

On [redacted] 6/2024, at 5:28AM, Resident 3 pushed their call bell for assistance to go to the bathroom. Staff Person A responded to the call bell. When Resident 3 requested assistance to the bathroom, Staff Person A refused to assist Resident 3 and instructed the resident to [redacted] and then Staff Person A would [redacted] Resident 3 in their bed. Resident 3 refused to urinate in [redacted] briefs and asked Staff Person A again to use the toilet. Staff Person A again refused to provide assistance to the bathroom and left the resident's room. At 6:45AM, Resident 3 pushed [redacted] call bell again and another staff person assisted Resident 3 to the bathroom. Resident 3 was frustrated and voiced anger in having to hold [redacted] for over an hour and told to urinate h[redacted] Staff Person A was t[redacted] as a result of this action.

Repeated Violation- 09/17/2024, et al and 04/01/2024, et al

Plan of Correction ***Accept [redacted] 12/24/2024)***

Immediate Corrective Action:

On 11/6/2024 the Wellness Director and Human Resources Manager conducted an investigation into the allegations against Staff Member A. Based on this investigation, Staff Member A was terminated on 11/6/2024.

Plan for Ongoing Compliance:

On 12/3/2024 the Administrator began weekly audits of 10% of the residents to determine if anyone feels neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.
On 12/18/2024 the Wellness Director held a clinical staff meeting to review resident rights.
Beginning on 12/23/2024 the Administrator will conduct the new hire training for resident rights and mandatory reporting of abuse and neglect. New hires will be expected to verbalize understanding of this regulation and demonstrate appropriate behavior before being cleared to provide direct resident care.
On 1/15/2025 the Wellness Director and Administrator will educate all clinical staff on resident rights, specifically relating to neglect, intimidation, physical and verbal abuse.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Implemented [redacted] - 03/13/2025)

44f - Written Decision

5. Requirements

2600.
44.f. Within 7 days after the submission of a written complaint, the home shall give the complainant and, if applicable, the designated person, a written decision explaining the home's investigation findings and the action the home plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless contraindicated by the support plan. If the home's investigation validates the complaint allegations, a resident who could potentially be harmed or his designated person shall receive a copy of the decision, with the name of the affected resident removed, unless contraindicated by the support plan.

Description of Violation

On, or around, 10/25/2024, Resident 4 and [redacted] expressed concerns of missing items from the resident's room to Staff Person B. Missing items included money in the form of cash ($50), a blanket, a ring, a bracelet, a pair of earrings, and a blank bank check. However, as of 11/21/2024, the home has not responded to or provided a status report of the alleged concerns.

44f - Written Decision *(continued)*

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:

On 11/22/2024 the Administrator spoke with Resident #4 regarding the alleged concerns and provided a status report regarding the ongoing investigation. Resident #4 voiced understanding and stated [redacted] was not concerned about the missing items any longer. The Administrator asked for permission to speak with [redacted] about the allegations and the resident agreed.

On 11/22/2024, during the on-site exit conference, the Administrator was educated by Department representatives on the regulation that within 7 days after the submission of a written complaint the home must give the complainant a written decision explaining the home's investigation findings and the action the home plans to take to resolve the complaint.

Plan for Ongoing Compliance:

On 11/25/2024 the Administrator spoke with Resident #4's [redacted] and provided an update on the alleged concerns from 10/25/2024.

Beginning 12/23/2024 the Administrator will treat all verbal complaints as written complaints and respond accordingly.

On 1/6/2025 the Administrator will begin conducting a weekly review of all complaints received to ensure that a written response has been given to each complainant within the 7-day timeframe.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

65a - FS Orientation 1st Day

6. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff Person C, who is a [redacted], has no documented date of hire. This staff person has worked at least 40 hours in the home and provides unsupervised care. However, this staff person has not completed the following trainings:

(1) Evacuation procedures.

(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

(5) The location and use of fire extinguishers.

(6) Smoke detectors and fire alarms.

(7) Telephone use and notification of emergency services.

Plan of Correction ***Accept[redacted] 01/07/2025)***

Immediate Corrective Action:

65a - FS Orientation 1st Day (continued)

On 11/25/2024 the Maintenance Director conducted orientation in general fire safety and emergency preparedness with Staff Person C.

Plan for Ongoing Compliance:
On 11/25/2024 the Wellness Director provided the Maintenance Director with a list of all direct care agency staff members who will need orientation in general fire safety and emergency preparedness prior to or during the first workday.
On 12/11/2024 the Wellness Director began reviewing the schedule on a weekly basis to ensure that any new direct care agency staff member is reported to the Maintenance Director so orientation in general fire safety and emergency preparedness can be completed in a timely manner.
Beginning 12/23/2024 the Business Office Manager will maintain record of the orientation in general fire safety and emergency preparedness in the staff member's personnel file.
On 1/6/2024 the Administrator educated the Maintenance Director and Wellness Director on the regulation that all direct care agency staff members must have orientation in general fire safety and emergency preparedness prior to or during the first workday.
By 1/17/2025 the Maintenance Director will complete first day orientation in general fire safety and emergency preparedness for all current direct care agency staff members.

Proposed Overall Completion Date: 01/17/2025

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented [redacted] - 03/13/2025)

65b - Rights/Abuse 40 Hours

7. 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:

Description of Violation

Staff Person C, who is a [redacted] has no documented date of hire. This staff person has worked at least 40 hours in the home and provides unsupervised care. However, this staff person has not completed the following trainings:
(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.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/25/2024 the Business Office Manager conducted orientation with Staff Person C in resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions.

Plan for Ongoing Compliance:
On 11/25/2024 the Wellness Director reviewed the schedule of all direct care agency staff members to determine if

65b - Rights/Abuse 40 Hours (continued)

any have worked 40 hours.
On 12/11/2024 the Wellness Director began reviewing the schedule of all direct care agency staff members on a weekly basis to monitor how many hours each agency staff member has worked.
Beginning 12/23/2024 the Business Office Manager will audit the nursing schedule on a weekly basis and track direct care agency staff member hours to ensure the proper orientation is completed within the first 40 scheduled working hours.
On 1/9/2025 the Administrator will educate the Wellness Director and Business Office Manager on the regulation that within 40 scheduled working hours all direct care staff persons, including agency staff members, must have an orientation on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions.
By 1/17/2025 the Business Office Manager will complete the Rights/Abuse 40 Hours training with all direct care agency staff members identified in the audit on 11/25/2024.

Proposed Overall Completion Date: 01/17/2025

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented [redacted] - 03/13/2025)

82c - Locking Poisonous Materials

8. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 11/21/2024 at 10:12AM, the janitor's closet across from resident room 20 was unlocked, unsupervised and accessible. The following chemicals and cleaning supplies were found in the closet:

- [redacted]

All chemicals have a manufacturer's label stating harmful if swallowed and to contact poison control if ingested. Resident 5's current assessment, dated [redacted]/2024, and current medical evaluation, dated [redacted]/2024, states the resident cannot safely use or avoid poisonous materials.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/21/2024, during the walk-through with the surveyor, the Administrator pulled the housekeeping closet door fully closed to ensure the locking mechanism engaged.

Plan for Ongoing Compliance:
On 11/25/2024 the Maintenance Director installed self-closing spring hinges on the door to the housekeeping closet and made the latch opening 1/8" larger to ensure the door latches securely.
On 11/26/2024 the Administrator began auditing closure of the housekeeping closet door to verify the door was

82c - Locking Poisonous Materials (continued)

locked securely. Audits are being done a minimum of 2 days each week at random times of the day.
On 1/9/2025 the Maintenance Director will educate all housekeeping and dietary staff members on the need to keep the housekeeping closet locked at all ties to adhere to the regulation that poisonous materials shall be kept locked and inaccessible to residents.

Proposed Overall Completion Date: 01/09/2025

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented [redacted] - 03/13/2025)

107b - Emergency Procedures

9. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.

Description of Violation

The home's written emergency procedures do not include the following:

- *Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.*
- *Means of transportation in the event that relocation is required.*

Repeated Violation- 05/21/2024

Plan of Correction ***Directed [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/26/2024, the Administrator revised the home's emergency plan and included the contact telephone numbers of local and state emergency management agencies and local resources for housing and emergency care of residents.
On 11/22/2024, during the on-site exit conference, the Administrator was educated by Department representatives on the regulation that the home must have a written emergency procedure that includes contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents as well as means of transportation in the event that relocation is required.

Plan for Ongoing Compliance:
On 11/28/2024 the Administrator contacted 5 different companies (3 medical transportation companies and 2 local ambulance companies) to ask if they would be willing to transport residents to another location in the event of an emergency.
As of 12/21/2024 the Administrator has received confirmation from 2 different transportation companies of their intent to provide transportation for residents in the event of an emergency.
On 12/30/2024 the Administrator will follow up with each company to secure a letter of agreement to add to the emergency procedure plan.
By 1/31/2025 the Administrator will secure a letter of agreement from each company that has agreed to partner with the home and transport residents to another location in the event of an emergency.

107b - Emergency Procedures (continued)

By 1/31/2025 the Administrator will update the home's written emergency procedures to include the transportation information.
By 12/31/2025 the Administrator will review all letters of agreement for transportation and update them as needed. These agreements will be reviewed on an annual basis to ensure resources are in place in the event of an emergency.

Proposed Overall Completion Date: 12/31/2025
Proposed Overall Completion Date: 01/31/2025

Directed Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

123b - Emergency Procedures Posted

10. Requirements

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

Description of Violation

On 11/21/2024, at 10:15AM, the home's emergency procedures were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/25/2024 the Administrator posted a copy of the Emergency Procedures policy in the display case in the front lobby and on the bulletin board in the employee break room. A copy is also kept in a binder on the table in the front lobby.
On 11/22/2024, during the on-site exit conference, the Administrator was educated by Department representatives on the regulation that the home must post a copy of the emergency procedures (relating to emergency preparedness) in a conspicuous and public place in the home and a copy shall be kept.

Plan for Ongoing Compliance:
Beginning on 1/1/2025 the Administrator will review the Emergency Procedures policy on an annual basis to ensure the home is in compliance with all statements in the written policy. A current copy of the policy will be maintained in the Policy and Procedure book in the Administrator's office and the Business Office.
On 1/6/2025 the Administrator began conducting a weekly audit to ensure the emergency procedures remain posted in a conspicuous and public place with easy access.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

143a - Emergency Medical Plan

11. Requirements

2600.
143.a. The home shall have a written emergency medical plan that includes the following:
2. Emergency transportation to be used.
3. An emergency-staffing plan.

Description of Violation

The home's emergency medical plan does not include the emergency transportation to be used or an emergency-staffing plan

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

Immediate Corrective Action:
On 11/28/2024 the Administrator contacted 5 different companies (3 medical transportation companies and 2 local ambulance companies) to ask if they would be willing to transport residents to another location in the event of an emergency.
On 11/22/2024, during the on-site exit conference, the Administrator was educated by Department representatives on the regulation that the home must have a written emergency medical plan that includes emergency transportation to be used and an emergency staffing plan.

Plan for Ongoing Compliance:
On 12/12/2024 the Administrator revised the emergency medical plan and included guidelines for an emergency staffing plan.
As of 12/21/2024 the Administrator has received confirmation from 2 different transportation companies of their intent to provide transportation for residents in the event of an emergency.
On 12/30/2024 the Administrator will follow up with each company to secure a letter of agreement to add to the emergency medical plan.
By 1/31/2025 the Administrator will secure a letter of agreement from each company that has agreed to partner with the home and transport residents to another location in the event of an emergency.
By 1/31/2025 the Administrator will update the home's written emergency procedures to include the transportation information.
By 12/31/2025 the Administrator will review all letters of agreement for transportation and update them as needed. These agreements will be reviewed on an annual basis to ensure resources are in place in the event of an emergency.

Proposed Overall Completion Date: 12/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

171b5 - First Aid Kit

12. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

171b5 - First Aid Kit *(continued)*

Description of Violation

On 11/22/2024, the first aid kit located in the home's van used to transport residents did not include eye coverings or a breathing shield.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:

0n 11/22/2024 the Maintenance Director added eye coverings and a breathing shield to the first aid kit in the home's van.

Plan for Ongoing Compliance:

On 12/2/2024 the Administrator began conducting biweekly audits of the first aid kit in the home's van to ensure that all required items are present.
On 1/10/2025 the Administrator will educate the Maintenance Director, Activities Director, and Owner on the items that must be present in the first aid kit in the home's van prior to providing transportation for any residents.

Proposed Overall Completion Date: 01/10/2025

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented [redacted] - 03/13/2025)

183d - Prescription Current

13. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 11/22/2024, at approximately 10:54AM, Eucerin cream was found in Resident 6's room. However, there is no current physician's order for this medication.

Plan of Correction ***Accept [redacted] 01/07/2025)***

Immediate Corrective Action:

On 11/22/2024 the Wellness Director removed the Eucerin cream from the resident's room and contacted the physician to request orders for the topical treatment.

Plan for Ongoing Compliance:

On 11/26/2024 the Wellness Director received orders from the primary care physician for the Eucerin cream.
On 12/2/2024 the Wellness Director and Wellness Coordinator began conducting weekly audits of the medication carts and resident rooms to ensure only current prescriptions, OTC, sample and CAM for individuals living in the home are being kept in the home.
On 1/15/2025 the Wellness Director will educate all medication technicians and nurses on the regulation that only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

183e - Storing Medications

14. 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

On 11/22/2024, at 11:18AM, there were blood glucose monitoring test strips prescribed to Resident 7 in the "East" medication cart. These test strips expired on 09/17/2021.

On 11/22/2024, at 11:21AM, there were two Gvoke Hypopens 1MG/0 0.4ML prescribed to Resident 8 located in the "East" medication cart. However, this medication was expired as of 10/2024.

On 11/22/2024, at 11:25AM, there was a bottle of docusate sodium 100MG prescribed to Resident 3 in the "East" medication cart. However, this medication was expired as of 07/2024.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/22/2024 the Wellness Coordinator removed the expired test strips, Gvoke Hypopens and docusate sodium from the medication cart and disposed of the medication appropriately. Physician orders were verified for each medication and replacement medication was requested as needed.

Plan for Ongoing Compliance:
On 12/2/2024 the Wellness Director and Wellness Coordinator began conducting weekly audits of the medication carts to ensure 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.
On 1/15/2025 the Wellness Director will educate all medication technicians and nurses on the regulation that 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.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

184a - Resident's Meds Labeled

15. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident 6 is prescribed Acetaminophen 500mg with orders to take 2 tablets by mouth twice daily. However, the home currently has two blister packs of this medication, each with different instructions for administration. One of the pharmacy labels states, "take 2 tablets by mouth once daily", and the other pharmacy label states, "take 2 tablets by mouth every 8 hours as needed".

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

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:

On 11/22/2024 the Wellness Coordinator contacted the primary care physician to confirm the correct dosage and instructions for administration of the prescribed acetaminophen 500mg. The blister packs were both labeled correctly and placed in the medication cart for future use.

Plan for Ongoing Compliance:

On 12/2/2024 the Wellness Director and Wellness Coordinator began conducting weekly audits of the medication carts to ensure that the original container for prescription medications shall be labeled with a pharmacy label that includes the prescribed dosage and instructions for administration.

On 1/15/2025 the Wellness Director will educate all medication technicians and nurses on the regulation that the original container for prescription medications shall be labeled with a pharmacy label that includes the prescribed dosage and instructions for administration.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented ([redacted] - 03/13/2025)

185a - Implement Storage Procedures

16. 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 9 is prescribed Ammonium Lactate 12% cream and Clobetasol 0.05% cream as needed. On 11/22/2024, at approximately 11:00AM, this medication was not available in the home.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:

On 11/22/2024 the Wellness Coordinator contacted the primary care physician to request that the prescribed ammonium lactate 12% cream and Clobetasol 0.05% cream be discontinued since the resident has not used the medications for over 8 months.

On 11/25/2024 the physician [redacted] responded "ok to discharge above meds." The medication list was updated to reflect the change in orders.

Plan for Ongoing Compliance:

On 12/2/2024 the Wellness Director and Wellness Coordinator began conducting weekly audits of the medication carts to ensure that medications and medical equipment are stored safely, accessible, secure and distributed by trained staff persons.

On 1/15/2025 the Wellness Director will educate all medication technicians and nurses on the regulation that medications and medical equipment must be stored safely, accessible, secure and distributed by trained staff persons.

Proposed Overall Completion Date: 01/31/2025

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

187a - Medication Record

17. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
11. Special precautions, if applicable.

Description of Violation

Resident 10 is prescribed Midodrine 2.5mg with orders to take 1 tablet by mouth three times daily, HOLD SBP 140 or greater. However, Resident 10's medication administration record (MAR) for November 2024 does not include the blood pressure readings taken to determine whether the medication should be held.

Plan of Correction ***Accept[redacted] - 12/26/2024)***

Immediate Corrective Action:
On 11/22/2024 the Wellness Director and Wellness Coordinator educated all nurses and medication technicians on the importance of reviewing the medication record to ensure all special precautions for administration are being followed. Education included how to take blood pressure readings and where to document the reading in the medication administration record.

Plan for Ongoing Compliance:
On 12/23/2024 the Wellness Director and Wellness Coordinator will begin conducting weekly audits of the medication administration records to ensure that all special precautions are being followed.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented [redacted] - 03/13/2025)

225a - Assessment 15 Days

18. 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 10's initial assessment and support plan, dated [redacted] 2024, includes the need for a bedrail to get in and out of bed. However, the assessment and support plan does not reflect the risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used nor whether a cover is required to meet FDA guidelines.

Repeated Violation- 04/01/2024, et al

Plan of Correction ***Accept[redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/26/2024 the Wellness Director updated the assessment and support plan to include the risks associated with

225a - Assessment 15 Days (continued)

the use of the bed rails, the resident's ability to use the device safely, and identification of the specific device to be used.

Plan for Ongoing Compliance:
On 12/23/2024 the Wellness Director will begin auditing assessment and support plans for those residents who have physician orders for bed rails to ensure all necessary documentation is present. The assessment and support plan will reflect the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used and whether a cover is required to meet FDA guidelines.
On 1/8/2025 the Administrator will educate the Wellness Director on the regulation that a resident must have a written initial assessment that is documented on the Department's assessment form within 15 days of admission.
On 1/13/2025 the Wellness Director will begin auditing all current RASPs to ensure compliance with this regulation. The initial audit of all RASPs will be completed by 1/31/2025 and will be conducted on a quarterly basis with subsequent deadlines of 4/30/2025, 7/31/2025, and 10/31/2025.

Proposed Overall Completion Date: 10/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 03/13/2025)

225c - Additional Assessment

19. 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 5's current assessment and support plan, dated [redacted]/2024, does not include the resident's wandering behavior or how the resident's behavioral needs will be met through staff support.

Resident 11 utilizes bilateral half-length bedrails. Resident 11's current assessment and support plan, dated [redacted]24, does not include the use of or the specific need for the resident's bedrails, the intended use, any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept [redacted] - 01/07/2025)***

Immediate Corrective Action:
On 11/25/2024 the Wellness Director updated the assessment and support plan for Resident #5 to include the resident's wandering behavior and how the behavioral needs will be met through staff support.
On 11/25/2024 the Wellness Director updated the assessment and support plan for Resident #11 to include the use of bilateral partial bedrails.

Plan for Ongoing Compliance:
On 12/23/2024 the Wellness Director will begin auditing assessment and support plans for those residents who

225c - Additional Assessment (continued)

have physician orders for bed rails to ensure all necessary documentation is present. The assessment and support plan will reflect the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used and whether a cover is required to meet FDA guidelines.
On 1/8/2025 the Administrator will educate the Wellness Director on the regulation that a resident must have an additional assessment if the condition of the resident significantly changes prior to the annual assessment.
On 1/13/2025 the Wellness Director will begin auditing all current RASPs to ensure compliance with this regulation. The initial audit of all RASPs will be completed by 1/31/2025 and will be conducted on a quarterly basis with subsequent deadlines of 4/30/2025, 7/31/2025, and 10/31/2025.

Proposed Overall Completion Date: 10/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] 03/13/2025)