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

February 21, 2025

[REDACTED], ADMINISTRATOR
135 VERMONT DRIVE OPERATING COMPANY LLC
[REDACTED]
[REDACTED]

RE: SERENITY GARDENS AT MOUNT CARMEL
135 VERMONT DRIVE
KULPMONT, PA, 17834
LICENSE/COC#: 23101

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/12/2024 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: *SERENITY GARDENS AT MOUNT CARMEL* **License #:** *23101* **License Expiration:** *11/21/2025*

Address: *135 VERMONT DRIVE, KULPMONT, PA 17834*

County: *NORTHUMBERLAND* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *135 VERMONT DRIVE OPERATING COMPANY LLC*
Address: [redacted]
Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *12/20/2001* **Issued By:** *DLI*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *12/12/2024*

Inspection Dates and Department Representative

12/12/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served:** *46*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *SDCU* **Capacity:** *22* **Residents Served:** *16*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *46*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *22* **Have Physical Disability:** *0*

Inspections / Reviews

12/10/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/16/2025*

01/31/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/14/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/07/2025*

Inspections / Reviews *(continued)*

02/11/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *02/14/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *02/14/2025*

02/21/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *02/14/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

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 55 PA Code Chapter 2600 regulations were not posted in a public conspicuous area of the home.

Plan of Correction ***Accept (- 01/31/2025)***

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.

A copy of Chapter 2600 regulations was placed in a conspicuous location on 12/12/24 the date of the inspection.

Administrator will monitor for ongoing compliance.

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

Implemented (- 02/21/2025)

82c - Locking Poisonous Materials

2. 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

An unattended cleaning cart was located in the homes Secured Dementia Care Unit (SDCU) that had a bucket of blue liquid. The liquid smelled like a cleaning solution. The residents resident on the homes SDCU are not assessed to safely handle and identify poisonous materials.

Plan of Correction ***Accept (- 02/11/2025)***

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.

On 12/12/24 Resident Care Coordinator emptied contents of bucket. On 12/13/24 Director of housekeeping reeducated housekeeping staff that carts must be locked when not in use or unattended. Cleaning bucket with locking lid was purchased and placed on cart in secure unit. Beginning on 1/6/25 Housekeeping Director of housekeeping began random weekly safety checks to ensure carts are locked when unattended. Director of Housekeeping will continue audits for a period of 6 weeks and until 100% compliance is reached for a period of 3 weeks.

Licensee's Proposed Overall Completion Date: *02/14/2025*

Implemented (- 02/21/2025)

91 - Telephone Numbers

3. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

91 - Telephone Numbers *(continued)*

Description of Violation

Resident # 2 did not have the required emergency telephone numbers posted by the resident's outgoing landline telephone in the resident's bedroom.

Plan of Correction ***Accept (- 01/31/2025)***

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.
4x4 frames were purchased for each room. Maintenance department will secure the frame containing all necessary information directly above each light switch in every residents room and next to each outgoing line in common areas to be completed by 1/31/25 for compliance. Administrator or designated person will perform quarterly audits for a period of 1 year and admission director will monitor upon each new admissions for ongoing compliance.

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

Implemented (- 02/21/2025)

100a - Exterior - Free of Hazards

4. Requirements

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

Description of Violation

There were several small pieces of broken glass near the home's dumpster.

Plan of Correction ***Accept (- 02/11/2025)***

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.
On 12/12/25 Director of maintenance swept area around dumpster and removed glass. Director of Maintenance or designated person will continue audit dumpster area after each trash pickup to ensure all trash is properly loaded from the dumpster. Any trash left outside of the dumpster will be cleaned. Maintenace director will monitor area for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 02/21/2025)

121a - Unobstructed Egress

5. Requirements

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

Description of Violation

There was a yellow and black cloth barrier pulled across the entrance to the home's dining room at time of inspection, blocking egress to the emergency exit located in the dining room.

The door in the back left corner of the dining room has an Exit sign above it. It also has two paper signs on it, one

121a - Unobstructed Egress (continued)

reading "DO NOT USE" and "Fire Exit Only – This Door is not to be used as an Exit." This signage may be confusing to an individual trying to evacuate in the event of an emergency.

Repeat Violation: 2-8-24

Plan of Correction ***Accept (█ - 02/11/2025)***

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.
Retractable safety barrier was removed from wall on 12/13/24 by the Director of Maintenance. Do not use sign was removed from door on date of survey 12/12/25 by Director of maintenance. Director of Maintenance will monitor that no signs are placed on exit door during monthly safety inspections for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (█ - 02/21/2025)

125a - Combustible Storage

6. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

The natural gas hot water heaters are located in the mechanical room. Directly behind the hot water heaters was a plastic Rubbermaid garbage can that contained industrial buffing pads, both flammable items, causing a potential fire hazard.

Plan of Correction ***Accept (█ - 02/11/2025)***

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.
On 12/12/24 plastic trash can and buffer pads were removed from the Mechanical Room by Director of Maintenance. Director of maintenance removed all combustible and flammable materials from mechanical room on 1/13/25. Maintenance Director or designated person will monitor for ongoing compliance during monthly building inspection.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (█ - 02/21/2025)

132c - Fire Drill Records

7. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

132c - Fire Drill Records *(continued)*

Description of Violation

The fire drill conducted on 7/12/274 at 207 does not indicate if the drill was conducted in the AM or PM.

Plan of Correction ***Accept (█ - 01/31/2025)***

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.
Fire drill log was altered to include a column for shift and am/pm. Director of Maintenance was educated on the additional column and to ensure all columns are filled in. Administrator will sign off on all drill logs each month for a period of 1 year to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (█ - 02/21/2025)

132g - Fire Drills Days/Times

8. 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 sleeping hours fire drills are routinely held between 5am and 6am, making them predictable.

Plan of Correction ***Accept (█ - 02/11/2025)***

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.
Beginnings on January 2025Director of maintenance will hold at least one sleeping fire drill between 11pm and 5 am. Director of Maintenace will log date and time of fire drill on drill log for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (█ - 02/21/2025)

141b1 - Annual Medical Evaluation

9. Requirements

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

Description of Violation

Resident #3's Documentation of Medical Evaluation (DME) dated █████ did not include Resident #3's weight and it didn't indicate the type of DME it was for, which describes the reason for the DME.

Plan of Correction ***Accept (█ - 02/11/2025)***

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

141b1 - Annual Medical Evaluation (continued)

On date of inspection 12/12/24
Primary Care was faxed to request form be completed in its entirety by Director of Wellness. Beginning 01/01/25 DOW and designated person (RCC) started an audit of all DME's. Audit was completed on 1/31/25. Any found errors were corrected. Beginning 2/1/25 DOW and designated person (RCC or MCC) will conduct a monthly audit of 5 random DME's and record findings on DME audit sheet for a period of 6 months and until no errors are found for a period of 4 consecutive weeks.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (█ - 02/21/2025)

181c - Self-administration Assessment

10. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2 has a bottle of Imodium and a bottle of laxative tablets in █ bedroom in a drawer near the recliner. Resident #2 is not currently assessed to self-administer medications.

Plan of Correction ***Accept (█ - 01/31/2025)***

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.
Resident #2 was educated on the importance of informing staff of all medications being kept in room. Resident #2 surrendered all medication in room on 12/12/24. On 01/15/25 orders were received to allow resident to keep medications at bedside. DOW updated RASP on 1/16/25. Resident will discuss any medications kept at bedside with Primary Care Physician for ongoing compliance.
Upon admission any new resident will be counseled by the Admissions Director and the DOW during the medication review on the importance about the importance being assessed to self-administer medications for ongoing compliance.

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

Implemented (█ - 02/21/2025)

187b - Date/Time of Medication Admin.

11. 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

On 12/4/24 at 2100, Resident # 4's medication administration record (MAR) was not documented to indicate that the resident's Olanzapine 5mg was administered.

On 12/7/24 at 0600, Resident # 4's MAR was not documented to indicate that the resident's Levothyroxine 25mcg

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

was administered.

On 12/6/24 at 0600, Resident # 5's MAR was not documented to indicate that the resident's Acetaminophen 325mg was administered.

On 12/6/24 at 0600, Resident # 5's MAR was not documented to indicate that the resident's Levothyroxine 100mcg was administered.

Plan of Correction ***Accept (█ - 01/31/2025)***

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. DOW will schedule retraining will all medical staff on properly document MAR.
On 12/13/25 DOW performed an audit of resident # 4 and #5 medication to ensure resident did receive the prescribed dose of medication. Before 2/10/25 DOW will re-educate all medical staff on proper documentation of MAR. Beginning 01/13/25 DOW and or designee will do weekly MAR audits to ensure compliance for a period of 6 weeks and until 100% compliance is reached for 3 consecutive weeks. DOW or designee will document results of each audit.

Licensee's Proposed Overall Completion Date: *02/22/2025*

Implemented (█ - 02/21/2025)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident # 6 has an order for accuchecks 4x daily before meals and at bedtime. The resident also receives insulin based on a sliding scale which is dependent upon the blood glucose reading. On 12/11/24 at 4:00pm the resident did not have a blood glucose reading completed or insulin based on a sliding scale utilizing this reading. Staff stated that the resident missed the reading due to being out of the building.

Resident # 7 has an order for blood glucose readings 3x daily and receives insulin based on a sliding scale. On 12/5/24 at 4pm, Resident #7's blood glucose was 140, which required 2 units of insulin to be administered based on the sliding scale. Per the resident's MAR, no insulin was administered based on the sliding scale.

Repeat Violation: 2-8-24

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

Plan of Correction ***Accept (- 02/11/2025)***

187.d. The home shall follow the directions of the prescriber.
State report was filed on date of inspection 12/12/24 for resident #6 by DOW.
DOW will re-educate all medical staff proper administration and documentation of medication with parameters by 02/12/25. The in-service will include what steps should be taken if a residents misses an insulin dose including a documented absence of building. Beginning 1/13/25 Director of Wellness or designated person (RCC or MCC) began to perform weekly audits of glucometer readings for accuracy and correct documentation. Audits will continue for a period of 6 weeks and until no errors are found for a period for 3 consecutive weeks. Findings will be recorded on an audit sheet for compliance.

Licensee's Proposed Overall Completion Date: *07/13/2025*

Implemented (- 02/21/2025)

225c - Additional Assessment

13. Requirements

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

Description of Violation

Resident #3's most recent Assessment portion of the Resident Assessment and Support Plan (RASP) was completed the previous one was completed

Plan of Correction ***Accept (- 02/11/2025)***

2600.
225.c.
The resident shall have additional assessments as follows:
1.
Annually.
Director of Wellness and Resident Care Coordinator completed an audit of all residents RASPS and due dates on 01/10/13. DOW created a log sheet to include date each residents RASP is due. DOW will monitor to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented (- 02/21/2025)

227d - Support Plan Medical/Dental

14. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

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

Description of Violation

The RASP for resident #3, dated [redacted] did not indicate the residents Behavioral and Cognitive care needs. The residents RASP dated [redacted] does not document how these needs will be met.

Repeat Violation: 2-8-24

Plan of Correction ***Accept ([redacted] - 02/11/2025)***

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

RASP for resident 3 was updated on [redacted] by DOW. Beginning on 1/13/25 DOW or designated person began an audit of all residents RASP for accuracy and completion. Audit was completed on 1/31/25. Beginning 2/1/25 DOW or designated person will conduct an audit on 5 random RASPS monthly and document findings and ensure all sections are completed in there entirety . DOW will continue reviews for 6 months and until there are 2 consecutive months with no errors for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented ([redacted] - 02/21/2025)

234e - Involvement/Participation

15. Requirements

2600.
234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

The RASP for Resident #8 dated [redacted], neither the resident nor the resident's designated person were involved in the participation of the support plan development.

Plan of Correction ***Accept ([redacted] - 01/31/2025)***

2600.
234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.
On January 15, 2025 a meeting was held with resident #8 POA to review and sign support plan.
DOW and RCC will perform an audit of all support plans to be completed no later than 1/31/25 to ensure all residents or designated persons were involved in the development of each support plan. DOW or designated person will audit 5 random charts each month for 6 months and document findings compliance.

234e - Involvement/Participation *(continued)*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 02/21/2025)

254a - Records Discharge/Active

16. Requirements

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

Description of Violation

At 1255 PM, the office with the resident records was found with the door open, there were no staff in sight, allowing access to resident personal information.

Plan of Correction ***Accept (- 01/31/2025)***

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.
On January 8, 2025 Director of maintenance removed magnetic door stop and adjusted hinge spring to allow door to close automatically upon entrance and exit. Director or wellness will monitor for ongoing complaince

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

Implemented (- 02/21/2025)