

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

June 30, 2025

[REDACTED]
CLARKS SUMMIT AID II OPCO LLC
[REDACTED]

RE: WILLOWBROOK PLACE
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 22659

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on [REDACTED] 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: WILLOWBROOK PLACE License #: 22659 License Expiration: 01/08/2026
Address: 150 EDELLA ROAD, CLARKS SUMMIT, PA 18411
County: LACKAWANNA Region: NORTHEAST

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: CLARKS SUMMIT AID II OPCO LLC
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 15 Total Daily Staff: 67 Waking Staff: 50

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint, Incident Exit Conference Date: 02/07/2025

Inspection Dates and Department Representative

12/18/2024 - Off-Site: [Redacted]
12/26/2024 - On-Site: [Redacted]
12/27/2024 - Off-Site: [Redacted]
01/21/2025 - Off-Site: [Redacted]
01/22/2025 - On-Site: [Redacted]
01/29/2025 - Off-Site: [Redacted]
02/05/2025 - Off-Site: [Redacted]
02/07/2025 - Off-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 80 Residents Served: 37

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: 37
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 15 Have Physical Disability: 0

Inspections / Reviews

12/18/2024 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *03/01/2025*

03/06/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *04/04/2025*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *03/10/2025*

03/19/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *04/04/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *04/08/2025*

06/30/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *04/04/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

16d - Final Incident Report

1. Requirements

2600.

16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department’s personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

The home failed to submit a final incident report to the Department regarding the death of Resident [REDACTED] following the initial incident report dated [REDACTED]

Plan of Correction

Directed [REDACTED] - 03/19/2025)

Plan of Correction – 2600.16(d) Final Incident Report

Immediate Corrective Action

Who is responsible: The Executive Director (ED) is responsible for addressing the immediate violation.

Action taken:

- On 2/20/2025, the Executive Director finalized and submitted the final incident report for Resident [REDACTED] to the appropriate authorities.
- Internal Investigation: The ED conducted an internal investigation from 11/11/2024 – 11/15/2024 to assess the incident.

Completion Date: 2/20/2025

Supporting Documentation:

- Exhibit 1: DHS Incident Reporting Form (Completed 2/20/2025)
- Exhibit 2: Internal Investigation Report (Completed 11/15/2024)

Preventative Actions to Ensure Compliance Moving Forward

Who is responsible:

- Executive Director (ED) and Resident Wellness Director (RWD)

Actions Taken & Timeline:

1. Re-education & Training:

o On 3/6/2025, the ED and RWD were re-educated on finalizing incident reports and reporting incidents immediately to the Department’s Personal Care Home Regional Office or Hotline following an investigation’s conclusion.

o Completion Date: 3/6/2025

o Supporting Documentation: Exhibit 3 – Record of Training (Completed 3/6/2025)

2. Audit of Reportable Incidents:

o Starting 3/3/2025 and continuing through 3/31/2025, the ED and Resident Care Director (RCD) will audit all state reportable events to ensure compliance.

o All reports will be finalized within 24 hours after the conclusion of the investigation and submitted to DHS.

o Completion Date: 3/31/2025

o Supporting Documentation: Exhibit 4 – Audit of DHS Reportable Events

3. Implementation of QA Monitoring System:

o Monthly Quality Assurance (QA) meetings will be held starting March 2025 for six months.

o Following this period, quarterly QA meetings will be held for an additional six months.

o These meetings will review compliance with incident reporting procedures and ensure sustainability.

o Completion Date: March 2026

4. Ongoing Compliance Monitoring:

16d Final Incident Report (continued)

*o The Executive Director is ultimately responsible for ensuring ongoing compliance with 55 Pa. Code 2600.16(d).
o All documentation related to incident reporting compliance will be retained both electronically and physically at the community.*

Final Compliance Deadline: 3/31/2025 (to allow for full reinforcement of reporting guidelines)

Proposed Overall Completion Date: 03/10/2025

(Directed)

In addition to the above noted plan: The home will train all staff members in reportable incidents and conditions including the homes internal policy and who is responsible for reporting on weekends and holidays.

Directed Completion Date: 04/08/2025

Implemented [REDACTED] - 05/05/2025)

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

On [REDACTED] at approximately 6:30 a.m. Resident [REDACTED] pulled their apartment door open from a seated position in their wheelchair. From there, the resident self propelled themselves down the hallway to the doorway to the second floor stairway, pushed the fire safe door open and wheeled themselves out onto the landing, down a flight of 5 steps and ended up on the landing between the first and second floors with the wheelchair along the side of the resident. Staff heard a commotion and went to see what happened. Upon finding the resident on the landing in a prone position on the floor they called 911 and the resident was sent to the ER for evaluation.

Multiple staff reported that Resident [REDACTED] was experiencing a decline in cognition over the last several months. Staff Member B, the Wellness Director, noted that the resident was due to have a new Resident Assessment and Support Plan (RASP) completed in another month and would be downgraded in areas of independence and cognitive functioning at that time. Staff Member B indicated that Resident [REDACTED] was experiencing a decline in cognition. Staff Member A, the homes Administrator, commented that it is the homes protocol for residents with cognitive decline to be moved to the 1st floor of the home.

It was also noted that originally three staff persons were scheduled for the 11p.m. 7a.m. shift [REDACTED], but one person called off and there was not a replacement found for that person. The shift was completed with only 2 direct care staff persons, a PCA and a med tech. The home had seventeen residents with mobility and supervision needs in the building at this time.

After resident [REDACTED] admission to the hospital on [REDACTED], resident [REDACTED] was transferred to hospice, palliative care on [REDACTED] and later passed away. The cause of death was multiple traumatic injuries, fall, and medical coagulopathy.

Plan of Correction

Directed [REDACTED] - 03/19/2025)

Plan of Correction 2600.42(b) Resident Rights & Abuse Prevention

42b - Abuse (continued)*Immediate Corrective Action*

Who is responsible: The Executive Director (ED) is responsible for addressing the immediate violation.

Actions Taken:

- *Internal Investigation: The Executive Director conducted an internal investigation from 11/11/2024 – 11/15/2024 regarding the incident.*
- *State Incident Report Submission: On 2/20/2025, the Executive Director finalized and submitted the State Incident Reportable to DHS, which was confirmed as received.*

Completion Date: 2/20/2025

Supporting Documentation:

- *Exhibit 1: Internal Investigation Report (Completed 11/15/2024)*
- *Exhibit 2: Finalized State Incident Reportable Form (Submitted 2/20/2025)*

*Preventative Actions to Ensure Compliance Moving Forward**Who is responsible:*

- *Executive Director (ED) and Resident Wellness Director (RWD)*

*Actions Taken & Timeline:**1. Staff Re-education on Reporting & Regulations:*

o What: The Executive Director scheduled an all-staff training session on 2/25/2025 to review Resident Rights under 55 Pa Code 2600.42, specifically 2600.42(b) regarding reporting incidents of potential neglect, abuse, mistreatment, corporal punishment, or any form of resident discipline.

o Staff unable to attend will receive one-on-one or small group retraining to ensure full participation.

o Completion Date: 3/14/2025

o Supporting Documentation:

? Exhibit 3: Record of Training – Resident Specific Rights (Completed 3/14/2025)

? Exhibit 5: Training Presentation on Resident Rights (Completed 3/14/2025)

2. Audit of State Reportable Incidents:

o What: The Executive Director and RWD will audit all state reportable incidents and staff-reported incidents for compliance with Resident Rights under 55 Pa Code 2600.42.

o Timeframe: One-month audit from 3/3/2025 to 4/2/2025

o Completion Date: 4/2/2025

o Supporting Documentation:

? Exhibit 4: Audit of State Reportable Incidents (Completion Date: 4/2/2025)

3. Re-education on Meeting Resident Needs:

o What: On 2/24/2025, the ED and RWD received retraining on meeting resident needs based on Pre-admission Screening, Durable Medical Equipment (DME), and Resident Assessments (RASP) to ensure compliance with 55 Pa Code 2600.42.

o Completion Date: 2/24/2025

o Supporting Documentation:

? Exhibit 6: Record of Training – Resident Needs (Completed 2/24/2025)

? Exhibit 7: Audit Plan for Resident Needs (Scheduled 3/3/2025 – Completion 3/14/2025)

4. Re-education on Resident-Specific Staffing Needs:

o What: On 2/24/2025, the ED and RWD were retrained on staffing levels based on Pre-admission Screening, DME, and RASP to ensure that staff allocations meet resident needs.

o Completion Date: 2/24/2025

o Supporting Documentation:

42b - Abuse (continued)

? Exhibit 9: Record of Training – Resident-Specific Staffing Needs (Completed 2/24/2025)

? Exhibit 10: Audit of Staffing Needs (Scheduled 3/3/2025 – Completion 3/14/2025)

5. Staffing Adjustments

o What: Immediately the Executive Director and Resident Wellness Director adjusted staffing levels to enhance care coverage on the second and third shifts in order to ensure adequate supervision based on identified mobility needs of the residents.

o What: The Executive Director, Resident Wellness Director, in conjunction with Regional Operations Specialist will collaborate to review each resident’s level of care and mobility assessment to ensure accuracy and that that staffing meets/exceeds minimum staffing hours required by 2600. 42(b). Completion date 3/14/2025.

o Supporting Documentation:

? Exhibit 12: Updated Staffing Schedule

6. Stairwell Safety Enhancements:

o What: To prevent unauthorized access and ensure resident safety, the Executive Director and Facilities Manager installed alarm systems (“screamers”) on all stairwell doors that integrate with the call bell system to alert staff when a door is opened.

o Completion Date: Implemented immediately and ongoing monitoring

Ongoing Compliance Monitoring & Sustainability Plan

1. Executive Director as Compliance Monitor:

o The Executive Director is ultimately responsible for ensuring ongoing compliance with DHS regulation guidelines under 55 Pa Code 2600.42.

2. Implementation of QA Monitoring System:

o Monthly Quality Assurance (QA) meetings will begin in March 2025 and continue for six months.

o After this period, quarterly QA meetings will be held for an additional six months.

o These meetings will review compliance with incident reporting, resident safety, and staffing regulations to ensure sustainability.

o Completion Date: March 2026

3. Retention of Documentation:

o All documentation related to compliance, audits, training, and staffing will be retained electronically and physically at the community for reference and verification.

Proposed Overall Completion Date: 03/10/2025

(Directed)

In addition to the above noted plan: The home will review the schedules daily to ensure adequate staffing is available on all shifts to meet the needs of the residents. The schedule will be signed by the reviewer. The home will hold weekly meetings starting 3/24/25 to ensure the residents needs are being met and update staffing hours accordingly.

Directed Completion Date: 04/08/2025

Implemented [redacted] - 05/06/2025)

60a - Staff/Support Plan

3. Requirements

2600.

60a - Staff/Support Plan (continued)

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 routinely staffs the overnight shift (11p.m.-7a.m.) with three staff members. On the [REDACTED] overnight shift only two staff members worked due to a call off. At this time thirty five residents were present in the building, seventeen of these residents required assistance to evacuate in the event of an emergency. One person required a two person assist to transfer, twelve residents required one person to transfer and four residents required initial cuing to get out of bed in the event of an emergency. The home has four internal fire safe areas and the residents require supervision in these areas once they are evacuated.

The letter dated [REDACTED] from the fire safety expert indicates a safe evacuation time of eight minutes and thirty five seconds based on the physical construction of the home. The homes most recent sleeping hours fire drill conducted on [REDACTED] at 5:55 a.m. indicates the staff evacuated the residents in nine minutes and twelve seconds with 8 staff members participating.

Two staff members is not enough staff to meet the residents needs in the event of an emergency as identified in their RASPS.

Plan of Correction

Directed [REDACTED] - 03/19/2025)

Plan of Correction – 2600.60(a) Staffing & Support Plan

Immediate Corrective Action

Who is responsible: The Executive Director (ED) and Resident Wellness Director ((RWD) are responsible for addressing the immediate violation.

Actions Taken:

- Increased Staffing Levels: On 11/15/2024, the Executive Director and RWD increased staffing levels to ensure adequate care coverage, adjusting the schedule.
- Completion Date: 11/15/2024

Supporting Documentation:

- Exhibit 1: Updated Staff Schedule (Completion Date: 3/1/2025)

Preventative Actions to Ensure Compliance Moving Forward

Who is responsible:

- Executive Director (ED)
- Resident Wellness Director (RWD)

Actions Taken:

1. Re-Evaluation of Residents LOC and Mobility assessment.
 - o What: The Executive Director, Resident Wellness Director, in conjunction with Regional Operations Specialist will collaborate to review each resident’s level of care and mobility assessment to ensure accuracy and that that staffing meets/exceeds minimum staffing hours required by 2600. 60(a). Completion date 3/14/2025.
 - o Mobility list will be updated based on this review and then reviewed weekly to as census and care needs change.
 - o Completion Date: 3/14/2025
 - o Ongoing Compliance: Resident status will be monitored continuously as census, cognitive, and physical needs change, and staffing will be adjusted accordingly.

Supporting Documentation:

- Exhibit 1: Updated Staff Schedule (Completion Date: 3/1/2025)
- 2. Re-Education on Staffing Requirements (55 Pa Code 2600.60(a))

60a - Staff/Support Plan (continued)

o *What: The Executive Director and RWD were re-educated on staffing requirements under 55 Pa Code 2600.60(a), ensuring that staffing meets the needs of residents as outlined in their assessment and support plans.*

o *Training Date: 3/6/2025 – 3/14/2025*

o *Completion Date: 3/14/2025*

Supporting Documentation:

- *Exhibit 2: Record of Training – Staffing & Resident Needs (Completed 3/14/2025)*

3. Audit of Staffing Levels & Compliance

o *What: The ED and RWD will conduct an audit of staffing levels under 55 Pa Code 2600.60(a) to ensure compliance with resident needs as specified in support plans.*

o *Audit Period: 3/6/2025 – 3/14/2025*

o *Completion Date: 3/14/2025*

Supporting Documentation:

- *Exhibit 3: Audit Report – Staffing & Resident Needs (Completed 3/14/2025)*

4. Fire Safety Compliance – Re-Evaluation of Evacuation Procedures

o *What:*

? *A fire drill evaluation was conducted to adhere to guidelines provided by the local Fire Chief.*

? *The evacuation time was corrected from 8 minutes 35 seconds to 9 minutes 30 seconds as documented in the updated fire inspection report from Fire Chief Sean Connolly on 11/10/2024.*

o *Completion Date: 11/10/2024*

Supporting Documentation:

- *Exhibit 4: Fire Inspection Letter (Completed 11/10/2024)*

Ongoing Compliance Monitoring & Sustainability Plan

1. Executive Director as Compliance Monitor:

o *The Executive Director is ultimately responsible for ensuring ongoing compliance with DHS regulation guidelines under 55 Pa Code 2600.60(a).*

2. Implementation of QA Monitoring System:

o *Monthly Quality Assurance (QA) meetings will be held starting March 2025 for six months.*

o *After this period, quarterly QA meetings will be held for an additional six months.*

o *These meetings will review compliance with staffing regulations, support plans, and resident needs to ensure sustainability.*

o *Completion Date: March 2026*

3. Retention of Documentation:

o *All documentation related to compliance, audits, training, and staffing will be retained electronically and physically at the community for reference and verification.*

Final Compliance Deadline: 3/14/2025 (allowing full implementation of corrective actions).

Proposed Overall Completion Date: 03/10/2025

(Directed)

In addition to the above noted plan: The home will review the schedules daily to ensure adequate staffing is available on all shifts to meet the needs of the residents. The schedule will be signed by the reviewer. A fire drill will be conducted during sleeping hours when no other staff members are available to participate other than third shift. If the home is unable to evacuate by the designated time, a subsequent drill will be conducted until the staffing ratio's on third shift are adequate.

60a - Staff/Support Plan (continued)

Directed Completion Date: 04/08/2025

Implemented () - 06/30/2025

132c - Fire Drill Records

4. Requirements

2600.

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

Description of Violation

The fire drill log notes a fire drill was conducted on [redacted] at 3:47, the time of the drill does not include if the drill was conducted in the AM or PM.

Plan of Correction

Directed [redacted] - 03/19/2025

Plan of Correction – 2600.132(c) Fire Drill Records

Immediate Corrective Action

Who is Responsible: Executive Director (ED) and Facilities Director

Action Taken:

- On 1/1/2025, the TELS building management platform was updated to require an AM or PM selection for fire drill logging. This ensures compliance with 55 Pa. Code 2600.132(c) by preventing missing or incomplete drill records.
- Completion Date: 1/1/2025
- Supporting Documentation: Exhibit 3 – TELS Digital Fire Drill Compliance Update (Completed 1/1/2025)

Preventative Actions to Ensure Compliance Moving Forward

Who is Responsible:

- Executive Director (ED)
- Facilities Director

Actions Taken & Timeline:

1. Re-Education on Fire Drill Documentation Requirements:

o What: The ED and Facilities Director will undergo re-education on fire drill documentation requirements to ensure all records include:

- ? Date and time of the drill
- ? Evacuation time
- ? Exit route used
- ? Number of residents in the home at the time
- ? Number of residents evacuated
- ? Number of staff participating
- ? Any problems encountered
- ? Whether fire alarm or smoke detector was operative

o Training Period: 3/3/2025 – 3/6/2025

o Completion Date: 3/6/2025

o Supporting Documentation: Exhibit 1 – Training on Fire Drill Documentation (Completed 3/6/2025)

2. Audit of Fire Drill Logs:

132c - Fire Drill Records (continued)

o What: The ED and Facilities Director will audit all fire drill records to verify compliance with 55 Pa. Code 2600.132(c).

o Audit Elements:

? Ensure that all required information is included in fire drill logs.

? Review any problems encountered during fire drills and ensure they are documented and addressed.

o Audit Period: 3/3/2025 – 3/14/2025

o Completion Date: 3/14/2025

o Supporting Documentation: Exhibit 2 – Fire Drill Log Audit Report (Completed 3/14/2025)

3. Implementation of Quality Assurance (QA) Monitoring System:

o What: To ensure continued compliance, monthly QA meetings will be held starting March 2025 for six months.

o After this period, quarterly QA meetings will be conducted for an additional six months to reinforce fire drill documentation compliance.

o Completion Date: March 2026

o Ongoing Responsibility: The Executive Director will monitor fire drill records as part of routine compliance reviews.

4. Retention of Fire Drill Documentation:

o What: All fire drill records will be retained electronically and physically for reference, audit purposes, and compliance verification.

o Retention Period: Ongoing

Final Compliance Deadline: 3/14/2025 (ensuring full implementation of corrective actions).

Proposed Overall Completion Date: 03/10/2025

(Directed)

In addition to the above noted plan: The Administrator will review the monthly fire drill logs after each drill, the logs will be initialed after review for 6 months.

Directed Completion Date: 04/08/2025

Implemented [redacted] 06/30/2025)

132d - Evacuation

5. Requirements

2600.

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

Description of Violation

The letter dated [redacted] from the fire safety expert indicates a safe evacuation time of 8 minutes and 35 seconds based on the physical construction of the home. The home fire drill conducted on [redacted] at 5:55 a.m. indicates the staff evacuated the residents in 9 minutes and 12 seconds.

132d Evacuation (continued)

The letter dated [REDACTED] from the fire safety expert indicates a safe evacuation time of 9 minutes and 30 seconds based on the physical construction of the home. The fire drill conducted on [REDACTED] at 6:03 a.m. indicates the staff evacuated the residents in 9 minutes and 34 seconds.

Plan of Correction**Directed [REDACTED] - 03/19/2025)**

Plan of Correction 2600.132(d) Evacuation

Immediate Corrective Action

Who is responsible: The Executive Director (ED) and Facilities Director are responsible for addressing the immediate violation.

Actions Taken:

- *Updated Fire Evacuation Time Documentation:*

- o *On 11/10/2024, an updated fire inspection report from Fire Chief Sean Connolly confirmed that the correct evacuation time is 9 minutes and 30 seconds instead of 8 minutes and 35 seconds as previously documented.*

- o *Completion Date: 11/10/2024*

- o *Supporting Documentation: Exhibit 1 Fire Chief Letter/ Fire Evacuation Time Documentation (Completed 11/10/2024)*

Preventative Actions to Ensure Compliance Moving Forward

Who is responsible:

- *Executive Director (ED)*

- *Facilities Director*

Actions Taken & Timeline:

1. *Re Education on Evacuation Requirements (55 Pa Code 2600.132(d))*

- o *What: The ED and Facilities Director will undergo re education on evacuation regulations to ensure compliance with 55 Pa Code 2600.132(d).*

- o *Training Topics Include:*

- ? *Evacuation procedures and timelines*

- ? *Requirement that residents must be able to evacuate the entire building to a public thoroughfare or a fire safe area designated in writing by a fire safety expert*

- ? *Fire safety expert requirements and documentation protocols*

- o *Training Period: 3/3/2025 3/14/2025*

- o *Completion Date: 3/14/2025*

- o *Supporting Documentation: Exhibit 2 Record of Training on Evacuation Requirements (Completed 3/14/2025)*

2. *Audit of Evacuation Documentation & Compliance*

- o *What: The ED and Facilities Director will conduct an audit of all evacuation documentation to verify compliance with 55 Pa Code 2600.132(d).*

- o *Audit Elements:*

- ? *Verification that evacuation procedures meet fire safety expert standards*

- ? *Review of resident evacuation times and compliance with written guidelines*

- ? *Confirmation that all documentation reflects up to date evacuation practices*

- o *Audit Period: 3/3/2025 3/14/2025*

- o *Completion Date: 3/14/2025*

132d - Evacuation (continued)

o Supporting Documentation: Exhibit 3 – Evacuation Compliance Audit Report (Completed 3/14/2025)

3. Implementation of Quality Assurance (QA) Monitoring System:

o What: To ensure continued compliance, monthly QA meetings will be held starting March 2025 for six months.

o After this period, quarterly QA meetings will be conducted for an additional six months to reinforce compliance with evacuation regulations.

o Completion Date: March 2026

o Ongoing Responsibility: The Executive Director will monitor compliance as part of routine facility operations.

4. Retention of Evacuation Documentation:

o What: All evacuation records will be retained electronically and physically for compliance verification, audit purposes, and reference.

o Retention Period: Ongoing

Final Compliance Deadline: 3/14/2025 (ensuring full implementation of corrective actions).

Proposed Overall Completion Date: 03/11/2025

(Directed)

In addition to the above noted plan: The Administrator will review the monthly fire drill logs after each drill, the logs will be initialed after review for 6 months. If the home is unable to evacuate all residents within the designated safe evacuation time the home will reassess residents needs, increase staffing ratios and conduct a subsequent fire drill until the evacuation time can be met.

Directed Completion Date: 04/08/2025

Implemented (████) - 06/30/2025)

132g - Fire Drills Days/Times

6. 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's fire drill log notes the following times for the sleeping hours fire drills completed in 2024: ██████ : 6:03 a.m., 3 staff participating, ██████ : 6:15 a.m., 6 staff participating, ██████ 6:29 a.m., 4 staff participating, and ██████ : 5:55 a.m., 8 staff participating.

The sleeping hour fire drills are routinely being completed at a predictable time and when more staff are available to participate in the fire drill. Dietary staff begin to arrive in the building at 5:30 a.m. and housekeeping staff arrive between 6:00 a.m. and 7:00 a.m.

Plan of Correction

Directed (████) - 03/19/2025)

Plan of Correction – 2600.132(g) Fire Drill Days/Times

132g - Fire Drills Days/Times (continued)

Immediate Corrective Action

Who is Responsible: Executive Director (ED) and Facilities Director

Action Taken:

- On 3/6/2025, the ED and Facilities Director conducted a non-routine fire drill during third shift at a non-standard time to ensure compliance with 55 Pa. Code 2600.132(g).
- Completion Date: 3/6/2025
- Supporting Documentation:
 - o Exhibit 3 – Initial 3rd Shift Non-Routine Fire Drill (Completed 3/6/2025)

Preventative Actions to Ensure Compliance Moving Forward

Who is Responsible:

- Executive Director (ED)
- Facilities Director

Actions Taken & Timeline:

1. Re-Education on Fire Drill Scheduling Requirements:

o What: The ED and Facilities Director will be re-educated on proper fire drill scheduling, ensuring drills are conducted:

- ? On different days of the week
- ? At various times of the day and night
- ? Without being routinely scheduled when extra staff are present
- ? During periods when resident attendance is at normal levels

o Training Period: 3/3/2025 – 3/14/2025

o Completion Date: 3/14/2025

o Supporting Documentation: Exhibit 1 – Training on Fire Drill Scheduling (Completed 3/14/2025)

2. Audit of Fire Drill Schedule & Compliance:

o What: The ED and Facilities Director will audit all fire drill records to ensure compliance with 55 Pa. Code 2600.132(g).

o Audit Elements:

- ? Confirm fire drills are scheduled at different days and times.
- ? Ensure fire drills are not conducted during low resident attendance or with extra staff.
- ? Review fire drill rotation across shifts.

o Audit Period: 3/6/2025 – 3/14/2025

o Completion Date: 3/14/2025

o Supporting Documentation: Exhibit 2 – Fire Drill Scheduling Audit Report (Completed 3/14/2025)

3. Ongoing Fire Drill Rotation Implementation:

o What: Fire drills will be scheduled on a rotating basis, ensuring:

- ? A different shift is tested each month.
- ? Different days of the week and times are used to maintain compliance.

o Ongoing Review: Each fire drill will be reviewed after completion to verify adherence to the rotation schedule.

o Accountability: The Executive Director will oversee fire drill scheduling and compliance.

4. Implementation of Quality Assurance (QA) Monitoring System:

o What: To ensure sustained compliance, monthly QA meetings will be held starting March 2025 for six months.

o After this period, quarterly QA meetings will be conducted for an additional six months to reinforce compliance with fire drill scheduling.

o Completion Date: March 2026

132g - Fire Drills Days/Times (continued)

o Ongoing Responsibility: The Executive Director will monitor fire drill schedules as part of regular facility operations.

5. Retention of Fire Drill Documentation:

o What: All fire drill records will be retained electronically and physically for compliance verification and audit purposes.

o Retention Period: Ongoing

Final Compliance Deadline: 3/14/2025 (ensuring full implementation of corrective actions).

Proposed Overall Completion Date: 03/10/2025

(Directed)

In addition to the above noted plan: A fire drill will be conducted during sleeping hours when no other staff members are available to participate other than third shift. If the home is unable to evacuate by the designated time, a subsequent drill will be conducted until the staffing ratio's on third shift are adequate.

Directed Completion Date: 04/08/2025

Implemented [REDACTED] - 05/05/2025)

141b1 - Annual Medical Evaluation

7. Requirements

2600.

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

Description of Violation

The annual Documentation Of Medical Evaluation (DME) dated [REDACTED] for resident #12 is incomplete. Section #9, Health Status, Physical and Cognitive is blank.

Plan of Correction

Directed [REDACTED] - 03/19/2025)

Plan of Correction – 2600.141(b)1 Annual Medical Evaluation

Immediate Corrective Action

Who is Responsible: Executive Director (ED) and Resident Wellness Director (RWD)

Action Taken:

• On 12/4/2024, the DME (Durable Medical Equipment) update for Resident #12 was completed and signed by the healthcare provider to ensure compliance with 55 Pa. Code 2600.141(b)1, which requires an annual medical evaluation for residents.

• Completion Date: 12/4/2024

• Supporting Documentation:

o Exhibit 1 – Updated DME Record (Completed 12/4/2024)

Preventative Actions to Ensure Compliance Moving Forward

Who is Responsible:

• Executive Director (ED)

• Resident Wellness Director (RWD)

Actions Taken & Timeline:

1. Re-Education on Annual Medical Evaluation Requirements:

o What: The ED and RWD will receive education from Regional Operations Specialist entitled Meeting the Needs of

141b1 - Annual Medical Evaluation (continued)

the Resident Based on the Pre-Admission, DME, and RASP on 55 Pa. Code 2600.141(b)1, which mandates that all residents receive a medical evaluation at least annually.

o Training Period: 3/3/2025 – 3/14/2025

o Completion Date: 3/14/2025

o Supporting Documentation:

? Exhibit 2 – Training on Annual Medical Evaluations (Completed 3/14/2025)

? Exhibit 2.1 – Training PowerPoint on Medical Evaluations (Completed 3/14/2025) : NOTE : ON FILE DOCUMENT TOO LARGE TO ATTACH

2. Audit of Resident Medical Evaluations & Compliance:

o What: The ED and RWD will audit all resident medical evaluations to verify compliance with annual medical evaluation requirements.

o Audit Elements:

? Confirm all residents have a current medical evaluation on file.

? Identify any overdue medical evaluations and schedule them immediately.

o Audit Period: 3/3/2025 – 3/14/2025

o Completion Date: 3/14/2025

o Supporting Documentation:

? Exhibit 3 – Audit Report on Resident Medical Evaluations (Completed 3/14/2025)

3. Implementation of Annual Medical Evaluation Tracking System:

o What: A tracking system will be implemented to ensure that all resident medical evaluations are scheduled and completed before expiration.

o Process:

? Medical evaluations will be reviewed at least 90 days before expiration.

? The RWD will maintain a digital and physical log of upcoming due dates.

o Ongoing Review: Tracking system will be reviewed monthly to ensure continued compliance.

o Accountability: The Executive Director will oversee the tracking system and confirm that all residents have valid annual medical evaluations.

4. Implementation of Quality Assurance (QA) Monitoring System:

o What: To ensure sustained compliance, monthly QA meetings will be held starting March 2025 for six months.

o After this period, quarterly QA meetings will be conducted for an additional six months to reinforce compliance with annual medical evaluations.

o Completion Date: March 2026

o Ongoing Responsibility: The Executive Director will monitor the tracking system and compliance.

5. Retention of Annual Medical Evaluation Documentation:

o What: All medical evaluation records will be retained electronically and physically for compliance verification and audit purposes.

o Retention Period: Ongoing

Final Compliance Deadline: 3/14/2025 (ensuring full implementation of corrective actions).

Proposed Overall Completion Date: 03/10/2025

(Directed)

In addition to the above noted plan: The administrator will audit all resident records to ensure that each resident has had a medical evaluation within the past year. Any resident whose medical evaluation is overdue will have a new evaluation completed. All new medical evaluations will be reviewed by the

141b1 - Annual Medical Evaluation (continued)

Administrator for required content.

Directed Completion Date: 04/08/2025

Implemented [redacted] - 05/06/2025)

225a - Assessment 15 Days

8. 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 # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The initial assessment was not completed until [redacted]
Resident # [redacted] was admitted to the home on [redacted]	The home did not complete an initial assessment.

Plan of Correction

Accepted [redacted] - 03/19/2025)

Plan of Correction – 2600.225(a) Initial Resident Assessments (Within 15 Days)

Immediate Corrective Action

Who is Responsible: Executive Director (ED) and Resident Wellness Director (RWD)

Action Taken:

- Audit of Resident Assessments:
 - o On 2/24/2025, the ED and RWD conducted an audit of resident assessments and identified cases where initial assessments were not completed within the required 15-day timeframe.
 - o Any overdue assessments were immediately scheduled and completed.
 - o Completion Date: 2/28/2025
 - o Supporting Documentation:
 - ? Exhibit 3 – Updated Resident Assessments (Completed 2/28/2025)

Preventative Actions to Ensure Compliance Moving Forward

Who is Responsible:

- Executive Director (ED)

225a - Assessment 15 Days (continued)

- Resident Wellness Director (RWD)

Actions Taken & Timeline:**1. Re-Education on Initial Resident Assessment Requirements:**

o *What: The ED and RWD will receive education from Regional Operations Specialist entitled Meeting the Needs of the Resident Based on the Pre-Admission, DME, and RASP on 155 Pa. Code 2600.225(a), which requires an initial written assessment to be completed within 15 days of a resident's admission.*

o *Training Period: 3/3/2025 – 3/14/2025*

o *Completion Date: 3/14/2025*

o *Supporting Documentation:*

? *Exhibit 1 – Training on Initial Resident Assessments (Completed 3/14/2025)*

? *Exhibit 2.1 - Refer to PowerPoint added in 2600.141 POC (Exhibit 2.1) Please note: ON FILE, FILE TO LARGE TO UPLOAD.*

2. Audit of Initial Resident Assessments & Compliance:

o *What: The ED and RWD will conduct an audit of all new resident assessments to ensure compliance with the 15-day timeframe.*

o *Audit Elements:*

? *Verify that all new residents have an initial assessment completed within 15 days of admission.*

? *Identify and correct any deficiencies immediately.*

o *Audit Period: 3/3/2025 – 3/14/2025*

o *Completion Date: 3/14/2025*

o *Supporting Documentation:*

? *Exhibit 2 – Audit Report on Initial Resident Assessments (Completed 3/14/2025)*

3. Implementation of Resident Assessment Tracking System:

o *What: A tracking system will be implemented to ensure that all initial assessments are completed within 15 days of a resident's admission.*

o *Process:*

? *The Resident Wellness Director will track new admissions and schedule initial assessments accordingly.*

? *The tracking system will issue alerts when an initial assessment is due within the next five days.*

o *Ongoing Review: Tracking logs will be reviewed weekly to ensure compliance.*

o *Accountability: The Executive Director will oversee the tracking system and confirm that all initial assessments are completed within the required timeframe.*

4. Implementation of Quality Assurance (QA) Monitoring System:

o *What: To ensure sustained compliance, monthly QA meetings will be held starting March 2025 for six months.*

o *After this period, quarterly QA meetings will be conducted for an additional six months to reinforce compliance with initial assessment regulations.*

o *Completion Date: March 2026*

o *Ongoing Responsibility: The Executive Director will monitor the tracking system and compliance.*

5. Retention of Resident Assessment Documentation:

o *What: All resident assessment records will be retained electronically and physically for compliance verification and audit purposes.*

o *Retention Period: Ongoing*

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

Implemented - 05/05/2025

225c Additional Assessment

9. Requirements

2600.

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

1. Annually.

Description of Violation

The annual assessment for Resident # [REDACTED] completed on [REDACTED] is missing information on "Ambulatory Status" on Page 3. It is Blank in Column 1 but marked as a B for the need. There is no description of services needed nor is there a plan to meet the need.

Resident [REDACTED] had a significant change assessment completed on [REDACTED], the previous assessment was completed on [REDACTED]

Plan of Correction**Directed [REDACTED] - 03/19/2025)**

Plan of Correction – 2600.225(c) Additional Resident Assessments for Significant Condition Changes

Immediate Corrective Action

Who is Responsible: Executive Director (ED) and Resident Wellness Director (RWD)

Action Taken:

- Audit of Resident Assessments for Significant Condition Changes:
 - o On 11/23/2023, Resident #1's assessment was reviewed, confirming that the resident had no significant changes before discharge on 11/3/2024.
 - o Medical documentation from [REDACTED] (11/17/2023) confirmed that the resident's condition remained stable during this period.
 - o Completion Date: 11/23/2023
 - o Supporting Documentation:
 - ? Exhibit 3 – Resident #1 RASP Review (Completed 11/23/2023)
 - ? Exhibit 4 – Medical Documentation from [REDACTED] (Completed 11/17/2023)

Preventative Actions to Ensure Compliance Moving Forward

Who is Responsible:

- Executive Director (ED)
- Resident Wellness Director (RWD)

Actions Taken & Timeline:

1. Re-Education on Additional Resident Assessments for Significant Condition Changes:
 - o What: The ED and RWD will receive education from Regional Operations Specialist entitled " Meeting the Needs of the Resident Based on the Pre-Admission, DME, and RASP" on 55 Pa. Code 2600.225(c), which requires that additional assessments be conducted if a resident's condition significantly changes prior to the annual assessment.
 - o Training Period: 3/3/2025 – 3/14/2025
 - o Completion Date: 3/14/2025
 - o Supporting Documentation:
 - ? Exhibit 1 – Training on Additional Resident Assessments for Significant Condition Changes (Completed 3/14/2025)
 - ? Add reference to training exhibit found in 2600 141 POC
2. Audit of Resident Assessments for Condition Changes & Compliance:
 - o What: The ED and RWD will conduct an audit of all resident assessments to verify that any significant changes in condition are documented and reassessed before the next annual assessment.

225c - Additional Assessment (continued)

o Audit Elements:

? Review all residents' records to ensure that any significant health or cognitive changes are being properly assessed.

? Ensure that updated assessments are completed and properly documented.

o Audit Period: 3/3/2025 – 3/14/2025

o Completion Date: 3/14/2025

o Supporting Documentation:

? Exhibit 2 – Audit Report on Resident Assessments for Condition Changes (Completed 3/14/2025)

3. Implementation of Resident Monitoring & Condition Tracking System:

o What: A condition tracking system will be implemented to ensure that any changes in a resident's health or cognitive status are promptly identified and assessed.

o Process:

? The Resident Wellness Director will review medical records and daily staff notes to identify any indications of a significant condition change.

? If a change is noted, an immediate reassessment will be scheduled to comply with 55 Pa. Code 2600.225(c).

o Ongoing Review: Tracking logs will be reviewed monthly to ensure compliance.

o Accountability: The Executive Director will oversee the tracking system and confirm that all resident condition changes are assessed and documented appropriately.

4. Implementation of Quality Assurance (QA) Monitoring System:

o What: To ensure sustained compliance, monthly QA meetings will be held starting March 2025 for six months.

o After this period, quarterly QA meetings will be conducted for an additional six months to reinforce compliance with reassessment requirements.

o Completion Date: March 2026

o Ongoing Responsibility: The Executive Director will monitor compliance with reassessment regulations.

5. Retention of Resident Assessment Documentation:

o What: All resident reassessment records will be retained electronically and physically for compliance verification and audit purposes.

o Retention Period: Ongoing

Final Compliance Deadline: 3/14/2025 (ensuring full implementation of corrective actions).

Proposed Overall Completion Date: 03/10/2025

Directed Completion Date: 04/08/2025

Implemented [REDACTED] - 05/05/2025)

10. 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 [REDACTED] had an annual assessment completed on [REDACTED]. Throughout the assessment period the resident began a gradual decline. Interviews with various staff members indicated that the resident was becoming more forgetful. The resident was being reminded of mealtimes by staff, the resident was calling for help in common areas rather than pushing their call button for assistance, the resident was needing more reminders about activities than in the past. The home did not complete an updated assessment based on the observed changes in the resident as they evolved/declined.

225c - Additional Assessment (continued)

Plan of Correction

Directed [REDACTED] - 03/19/2025)

*Plan of Correction – 2600.225(c) Annual Resident Assessments**Immediate Corrective Action**Who is Responsible: Executive Director (ED) and Resident Wellness Director (RWD)**Action Taken:*

- *Audit of Resident Assessments:*

- o *On 3/3/2025, the ED and RWD began a full audit of resident assessments to verify that all residents have received an annual assessment as required by 55 Pa. Code 2600.225(c).*

- o *Any overdue assessments were identified, and corrective actions were taken to ensure compliance.*

- o *Completion Date: 3/14/2025*

- o *Supporting Documentation:*

- o *? Exhibit 2 – Audit Report on Annual Resident Assessments (Completed 3/14/2025)*

*Preventative Actions to Ensure Compliance Moving Forward**Who is Responsible:*

- *Executive Director (ED)*

- *Resident Wellness Director (RWD)*

Actions Taken & Timeline:

1. *Re-Education on Annual Resident Assessment Requirements:*

- o *What: The ED and RWD will receive education from Regional Operations Specialist entitled " Meeting the Needs of the Resident Based on the Pre-Admission, DME, and RASP" on 55 Pa. Code 2600.225(c), which requires that each resident receives an annual assessment to evaluate their physical, cognitive, and medical needs.*

- o *Training Period: 3/3/2025 – 3/14/2025*

- o *Completion Date: 3/14/2025*

- o *Supporting Documentation:*

- o *? Exhibit 1 – Training on Annual Resident Assessments (Completed 3/14/2025)*

- o *? Refer to the PowerPoint training curriculum in 2600.141 POC (Exhibit 2.1)*

2. *Audit of Resident Assessments & Compliance:*

- o *What: The ED and RWD will conduct a weekly audit of all resident assessments for a period of one month to ensure compliance with the annual assessment requirement.*

- o *Audit Elements:*

- o *? Verify that all residents have a valid and up-to-date annual assessment.*

- o *? Identify and immediately correct any deficiencies.*

- o *Audit Period: 3/3/2025 – 3/14/2025*

- o *Completion Date: 3/14/2025*

- o *Supporting Documentation:*

- o *? Exhibit 2 – Weekly Audit Reports on Annual Resident Assessments (Completed 3/14/2025)*

3. *Implementation of Resident Assessment Tracking System:*

- o *What: A tracking system will be implemented to ensure that all annual assessments are completed before their due date.*

- o *Process:*

- o *? The Resident Wellness Director will maintain a log of due dates for all resident assessments.*

- o *? The tracking system will generate alerts when an assessment is due within 30 days.*

- o *Ongoing Review: Tracking logs will be reviewed monthly to ensure compliance.*

225c - Additional Assessment (continued)

o *Accountability: The Executive Director will oversee the tracking system and confirm that all residents receive their annual assessment as required.*

4. Implementation of Quality Assurance (QA) Monitoring System:

o *What: To ensure sustained compliance, monthly QA meetings will be held starting March 2025 for six months.*

o *After this period, quarterly QA meetings will be conducted for an additional six months to reinforce compliance with annual assessment regulations.*

o *Completion Date: March 2026*

o *Ongoing Responsibility: The Executive Director will monitor the tracking system and compliance.*

5. Retention of Resident Assessment Documentation:

o *What: All resident assessment records will be retained electronically and physically for compliance verification and audit purposes.*

o *Retention Period: Ongoing*

Final Compliance Deadline: 3/14/2025 (ensuring full implementation of corrective actions).

Proposed Overall Completion Date: 03/10/2025

(Directed)

In addition to the above noted plan: The home will audit all resident records to ensure all assessments are accurate and complete. The home will hold weekly meetings starting 3/24/25 to ensure if the residents care needs change they are being addressed and residents needs are being met. The home will create a tracking sheet to track these updates during the meetings. Documentation will be kept.

Directed Completion Date: 03/10/2025

Implemented [REDACTED] - 05/05/2025)