

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

February 26, 2025

[REDACTED], ADMINISTRATOR
UMH PA CORP
50 WEST TIOGA STREET
TUNKHANNOCK, PA, 18657

RE: TUNKHANNOCK MANOR
50 WEST TIOGA STREET
TUNKHANNOCK, PA, 18657
LICENSE/COC#: 23655

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *TUNKHANNOCK MANOR* License #: *23655* License Expiration: *12/08/2024*
 Address: *50 WEST TIOGA STREET, TUNKHANNOCK, PA 18657*
 County: *WYOMING* Region: *NORTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *UMH PA CORP*
 Address: *50 WEST TIOGA STREET, TUNKHANNOCK, PA, 18657*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *06/18/2023* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *33* Waking Staff: *25*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *01/16/2025*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *38* Residents Served: *25*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Entire Home* Capacity: *38* Residents Served: *8*

Hospice
 Current Residents: *0*

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: *8* Have Physical Disability: *0*

Inspections / Reviews

01/16/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/09/2025*

02/10/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *02/25/2025*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/17/2025*

Inspections / Reviews *(continued)*

02/18/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/25/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 02/25/2025

02/26/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/25/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contracts for Resident 1, dated [REDACTED] and Resident 2, dated [REDACTED], were not signed by the residents.

Plan of Correction

Accept ([REDACTED] - 02/10/2025)

Resident #1 and #2's contracts were updated with signatures from each resident on 1/17/25. Administrator was re-educated on 1/16/25 on the need to have contracts signed by the resident themselves, along with the residents responsible party if agreed upon. Administrator audited all resident contracts on 1/17/25 to verify all were signed by the resident.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented ([REDACTED] - 02/26/2025)

64c - Annual Training

2. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

During an on-site inspection performed 1/16/25, the Administrator could only produce verification that 7 hours were completed of the required 24 hours of annual training.

Plan of Correction

Accept ([REDACTED] - 02/18/2025)

The Administrator will enroll in and complete the previously needed 17 hours of required training, in addition to the 24 hours of annual training required within this calendar year. The Administrator will complete at least 11 hours of training per quarter to ensure full compliance. Training will be obtained through state-approved providers. Training certificates and transcripts will be maintained in the administrator's personnel file for auditing purposes.

Licensee's Proposed Overall Completion Date: 02/15/2025

Implemented ([REDACTED] - 02/26/2025)

82c - Locking Poisonous Materials

3. 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

In the Bathroom in east hallway, an aerosol can of Clorox and an air freshener were found unlocked under the bathroom sink. There are residents in the home that are not assessed to be safely around poisonous materials.

82c - Locking Poisonous Materials (continued)

Repeat Violation: 3/5/2024

Plan of Correction**Accept (█) - 02/10/2025)**

Both items were immediately removed on 1/16/25. All staff will be educated by 2/16/25 on the regulation regarding Poisonous materials shall be kept locked and inaccessible to residents. The Administrator started weekly audits 1/17/25 to ensure poisonous materials are not accessible to residents. Audit will be reevaluated in 3 months. Administrator will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented (█) - 02/26/2025)**103e - Left Overs****4. Requirements**

2600.

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

Description of Violation

On 1/16/25 at 2:00 pm, the refrigerator located in the kitchen had a tray of jello cups that were not dated.

Plan of Correction**Accept (█) - 02/10/2025)**

Kitchen staff on shift received immediate re-training on proper food labeling and storage guidelines. Dietary Supervisor audited all food in kitchen on 1/16/25 to verify compliance with the regulation. Visual signage has been posted in the kitchen as a reminder. The Dietary Supervisor will perform daily checks to ensure compliance.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented (█) - 02/26/2025)**132c - Fire Drill Records****5. 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

During an onsite inspection performed 1/16/25, the Fire drill logs for 2024 do not include full dates. They only list the month and day and, not the year for June through December.

Plan of Correction**Accept (█) - 02/10/2025)**

Maintenance Supervisor was educated on 1/16/25 on proper dating of the documented fire drills. Fire drill dates were updated by the Maintenance Supervisor on 1/16/25 by listing the proper date they were performed, including the year. Administrator will audit monthly fire drills to ensure compliance with proper dating.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented (█) - 02/26/2025)

141b1 - Annual Medical Evaluation

6. Requirements

2600.

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

Description of Violation

Resident 3's most recent annual documentation of medical evaluation dated [REDACTED] did not include the medical professionals name or license number.

Plan of Correction

Accept ([REDACTED] - 02/10/2025)

Resident #3's DME was updated with doctors name and license number on 1/17/25. Nursing Supervisor was re-educated on the regulation that a medical evaluation shall be completed at least annually, and with the proper information. Administrator audited all residents DME's 1/20/25 to ensure all were in compliance. Nursing Supervisor will audit DME's as they are completed annually for each resident as they are returned from the medical professional.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented ([REDACTED] - 02/26/2025)

231b - Medical Evaluation

7. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] however, the resident's medical evaluation was not completed until [REDACTED]

Repeat Violation: 3/5/2024

Plan of Correction

Accept ([REDACTED] - 02/10/2025)

Administrator and Nursing Supervisor were educated on 1/16/25 on regulation regarding that a resident should have a medical evaluation completed within 60 days prior to admission. Administrator will inform new memory care admissions and responsible parties during the preadmission screening process that this evaluation and document must be completed by move in date. Administrator will ensure compliance with this regulation on admission date.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented ([REDACTED] - 02/26/2025)

231e - No Objection Statement

8. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 1 was admitted to the secured dementia unit on [REDACTED] and Resident 2 was admitted on [REDACTED] The

231e - No Objection Statement (continued)

home did not have documentation that Resident 1 and Resident 2, along with their designees, did not object to the resident's transfer to the secure dementia care unit.

Plan of Correction

Accept (█) - 02/10/2025

Resident #1 and #2's agreements were updated with the consent to be in a secured dementia care facility on 1/17/25. Administrator audited all residents contracts on 1/20/25 to locate the addendum to ensure compliance that every resident and designee has given consent to be in a secured dementia care facility.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented (█) - 02/26/2025