

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

May 12, 2025

[REDACTED], FOUNDED MEMBER
RC KNICKERBOCKER, LLC
304 SOUTH SECOND STREET
CLEARFIELD, PA, 16830

RE: KNICKERBOCKER VILLA
304 SOUTH SECOND STREET
CLEARFIELD, PA, 16830
LICENSE/COC#: 45528

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/25/2025 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: *KNICKERBOCKER VILLA* License #: *45528* License Expiration: *01/01/2026*
 Address: *304 SOUTH SECOND STREET, CLEARFIELD, PA 16830*
 County: *CLEARFIELD* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *RC KNICKERBOCKER, LLC*
 Address: *304 SOUTH SECOND STREET, CLEARFIELD, PA, 16830*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *02/25/2015* Issued By: *Clearfield Boro*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *38* Waking Staff: *29*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Complaint, Incident* Exit Conference Date: *02/25/2025*

Inspection Dates and Department Representative

02/25/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *70* Residents Served: *30*

Secured Dementia Care Unit
 In Home: *Yes* Area: *SDCU* Capacity: *17* Residents Served: *8*

Hospice
 Current Residents: *1*

Number of Residents Who:
 Receive Supplemental Security Income: *1* Are 60 Years of Age or Older: *29*
 Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *8* Have Physical Disability: *0*

Inspections / Reviews

02/25/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/28/2025*

04/11/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *04/21/2025*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/18/2025*

Inspections / Reviews *(continued)*

04/18/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/21/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/22/2025

05/12/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/21/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

25c2 - Fee Schedule

1. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

- 2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

The home charges specified amounts for individual personal needs services. The resident-home contract , dated [redacted] for resident #1 does not include a fee schedule of actual amounts charged for available services.

The home charges specified amounts for individual personal needs services. The resident-home contract , dated [redacted] for resident #2 does not include a fee schedule of actual amounts charged for available services.

The home charges specified amounts for individual personal needs services. The resident-home contract , dated [redacted] for resident #3 does not include a fee schedule of actual amounts charged for available services.

The home charges specified amounts for individual personal needs services. The resident-home contract , dated [redacted] for resident #4 does not include a fee schedule of actual amounts charged for available services.

Plan of Correction

Accept ([redacted] - 04/18/2025)

Administrator failed to ensure the fee schedule was filed in the charts of Resident#1, Resident #2, Resident #3, and Resident #4. Immediately fee schedules were filed in each chart by the Administrator on 2/25/25. On 2/26/25 a checklist was implemented by the Administrator, to ensure all documents are filed along with the homes contract, upon each admission. Ongoing the Administrator will utilize the checklist to ensure all forms are placed in Residents charts.

Licensee's Proposed Overall Completion Date: 04/14/2025

Implemented ([redacted] - 05/12/2025)

63a - First Aid/CPR Training

2. Requirements

2600.

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

Description of Violation

From 7:30 p.m. on 2/18/25 to 3:00 a.m. on 2/19/25, 30 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction

Accept ([redacted] - 04/18/2025)

Administrator failed to ensure at least one DCS scheduled on 2/18/25 was certified in CPR. On 2/26/25 the Administrator scheduled all un-certified staff for CPR/First Aid training, and training was completed on 3/12/25. 2/26/25 and ongoing the Administrator will ensure at least one DCS with CPR certification will be scheduled with a census less than 50 residents. CPR/First aid training is added to the annual staff training by the Administrator.

Licensee's Proposed Overall Completion Date: 04/14/2025

63a - First Aid/CPR Training (continued)

Implemented () - 05/12/2025

88a - Surfaces

3. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The ceiling in the small conference room was actively leaking a dark brown substance which stained 2 ceiling tiles, 1 of which was hanging down approximately 8" from the ceiling. The dark liquid was leaking into a 1/2 full 5-gallon bucket throughout the day.

Plan of Correction

Accept () - 04/18/2025

During the Maintenance Director's daily inspection of the facility on 2/23/25, a leak was observed in the small conference room. Immediately () Roofing was notified by the Administrator. The roofing company repaired the roof on 2/24/25. On 2/25/25 during daily inspection of the facility, Maintenance observed water coming from the ceiling in the small conference room, and a bucket was placed to catch the water. Immediately, the roofing company was contacted. () roofing arrived on 3/5/25 during heavy rains, and the area was no longer leaking. The leak found on 2/25/25 was from residual water from the previous leak. Ceiling tiles were replaced on 3/7/25 by the Maintenance Director. 2/26/25 and ongoing the Maintenance Director will continue to inspect the facility daily, and report any repairs needed to the Administrator immediately. On 2/26/25 the Administrator started with a daily walk through of the entire facility.

Licensee's Proposed Overall Completion Date: 04/14/2025

Implemented () - 05/12/2025

100b - Removal Snow/Obstructions

4. Requirements

2600.

100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

At 11:15 a.m., the exterior walkway outside emergency exit door #6 was covered with approximately 2" of snow/ice.

Plan of Correction

Accept () - 04/11/2025

The Maintenance Director failed to monitor exit door #6 to ensure it was unobstructed from snow/ice before 11:05am. Immediately, Maintenance shoveled the snow/ice, and applied salt. 2/26/25 and ongoing the Administrator will review weekly, the tracking system that the Maintenance Director documents daily of ensuring all exits doors are unobstructed. The Administrator will do a daily walk through of the facility.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented () - 05/12/2025

101j1 - Mattress Fire Retardant

5. Requirements

2600.

101j1 - Mattress Fire Retardant (continued)

101.j. Each resident shall have the following in the bedroom:

- 1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

There were 2 approximate 1" tears in the mattress on resident #3's bed, 1 of which exposed a sharp end of a metal spring.

Plan of Correction

Accept (█) - 04/18/2025

DCS failed to inspect/report resident #3's mattress being torn with springs showing. Immediately, a new mattress was placed in resident #3's bedroom on 2/25/25 by the Maintenance Director. 2/26/25 and ongoing the Administrator will review weekly, the tracking system that the DCS documents daily of ensuring all mattress's are in good repair and free from hazards upon each bed change. Starting on 2/26/25, the Administrator will do a daily walk through of the facility.

Licensee's Proposed Overall Completion Date: 04/14/2025

Implemented (█) - 05/12/2025

103f - Refrigerator/Freezer Temps

6. Requirements

2600.

- 103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 10:49 a.m., there was no thermometer in the main refrigerator in the kitchen.

Plan of Correction

Accept (█) - 04/18/2025

The Dietary staff failed to ensure a thermometer was in the main refrigerator on 2/25/25 at 10:49am. Immediately, a thermometer was placed in the main refrigerator by the Dietary Cook. 2/26/25 and ongoing the Administrator will review weekly, the tracking system that the Dietary Department documents daily of ensuring thermometers are in all refrigerators. Starting on 2/26/25, the Administrator will do a daily walk through of the facility.

Licensee's Proposed Overall Completion Date: 04/14/2025

Implemented (█) - 05/12/2025

121a - Unobstructed Egress

7. 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

At 11:05 a.m., approximately 2" of snow and ice on the exterior walkway prevented emergency exit door #6 to fully open. The door could only be opened approximately 8".

121a - Unobstructed Egress (continued)

Plan of Correction

Accept (█) - 04/11/2025)

The Maintenance Director failed to monitor exit door #6 to ensure it was unobstructed for egress on 2/25/25 before 11:05am. Immediately, Maintenance shoveled the snow/ice, and applied salt. 2/26/25 and ongoing the Administrator will review weekly, the tracking system that the Maintenance Director documents daily of ensuring all exits doors are unobstructed. The Administrator will do a daily walk through of the facility.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 05/12/2025)

185a - Implement Storage Procedures

8. 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 #2 was prescribed Novolog Flexpen Syringe subcutaneous injections four times per day per sliding scale:

151-200 = 3 units

201-250 = 5 units

251-300 = 7 units

301-350 = 9 units

351-400 = 11 units

> 400 = 11 units and call provider

On 2/20/25 at 9:23 p.m., resident #2's blood glucose level was 198; however, the resident's February 2025 medication administration record (MAR) indicated the resident's blood glucose level was 146.

On 2/20/25 at 6:00 a.m., resident #2's February 2025 MAR indicated a blood glucose level of 300; however, this reading was not on the resident's glucometer.

On 2/20/25 at 12:30 p.m., resident #2's February 2025 MAR indicated a blood glucose level of 300; however, this reading was not on the resident's glucometer.

On 2/25/25 at 12:00 p.m., the resident's glucometer was not set to the correct date and time.

Resident #5 was prescribed blood glucose tests twice daily.

On 2/17/25 at 6:11 a.m., resident #5's blood glucose level was 88; however, the resident's February 2025 MAR indicated the resident's blood glucose level was 98.

On 2/20/25 at 10:42 p.m., resident #5's blood glucose level was 233; however, the resident's February 2025 MAR indicated the resident's blood glucose level was 388.

The following blood glucose levels are documented on resident #5's February 2025 MAR; however, were not on the resident's glucometer:

Date: **Time:** **Blood Glucose Level:**

185a - Implement Storage Procedures (continued)

2/22/25	10:19 p.m.	248
2/23/25	8:40 p.m.	168

Resident #7 was prescribed blood glucose tests twice daily.

On 2/20/25 at 9:05 a.m., resident #5's blood glucose level was 171; however, the resident's February 2025 MAR indicated the resident's blood glucose level was 161.

Plan of Correction

Accept (█) - 04/18/2025)

On 2/20/25 and 2/25/25 the Medication Technician failed to follow the directions of the prescriber for Resident #2. On 2/17/25, 2/20/25, 2/22/25, and 2/23/25 the Medication Technician failed to follow the directions of the prescriber for Resident #5. On 2/20/25 the Medication Technician failed to follow the directions of the prescriber for Resident #7. A mandatory meeting was held on 3/3/25 by the Care Coordinator educating the 5 rights of Medication Administration, proper documentation of accu-checks, and following a sliding scale the physician prescribes. Immediately an audit was implemented by the Care Coordinator, to ensure proper documentation and proper administration of medication is provided each shift. Audits are completed once a week by the Care Coordinator. 3/7/25 and on going the Administrator will review the audits weekly, and continue regular in-services/education on the 5 rights of medication administration.

Licensee's Proposed Overall Completion Date: 04/14/2025

Implemented (█) - 05/12/2025)

187b - Date/Time of Medication Admin.

9. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 was prescribed furosemide 40mg tablet, take 1 tablet by mouth daily. On 2/25/25 at 8:00 a.m., staff person A initialed the resident's February 2025 MAR indicating the medication was administered. However, the medication was not available in the home.

Plan of Correction

Accept (█) - 04/18/2025)

On 2/25/25 at 8am staff person A failed to document properly that medication was not available to administer. A mandatory meeting was held on 3/3/25 by the Care Coordinator educating the 5 rights of Medication Administration, proper documentation of accu-checks, and following the physicians orders. Immediately an audit was implemented by the Care Coordinator, to ensure proper documentation, proper administration of medication, and ensuring medications are onsite. Audits are completed once a week by the Care Coordinator. Staff will monitor each shift. 3/7/25 and on going the Administrator will review the audits weekly, and continue regular in-services/education on the 5 rights of medication administration.

Licensee's Proposed Overall Completion Date: 04/14/2025

Implemented (█) - 05/12/2025)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident #2 was prescribed Novolog Flexpen Syringe subcutaneous injections four times per day per sliding scale:

- 151-200 = 3 units
- 201-250 = 5 units
- 251-300 = 7 units
- 301-350 = 9 units
- 351-400 = 11 units
- > 400 = 11 units and call provider

On 2/24//25 at 6:20 a.m., resident #2's blood glucose level was 77. However, the resident's February 2025 MAR indicates the resident's blood glucose level was 300. Resident #2 was administered 7 units of Novolog. However, according to the prescriber's orders, no Novolog should have been administered.

On 2/24//25 at 12:00 p.m. resident #2's February 2025 MAR indicates the resident's blood glucose level was 300, and the resident was administered 7 units of Novolog. However, there was no blood glucose reading for this date and time on the resident's glucometer and the resident was administered 7 units of Novolog.

Plan of Correction

Accept (█ - 04/18/2025)

On 2/24/25 at 6:20am and 12:00pm the Medication Technician failed to follow the directions of the prescriber for Resident #2. A mandatory meeting was held on 3/3/25 by the Care Coordinator, educating the 5 rights of Medication Administration, proper documentation of accu-checks, and following a sliding scale the physician prescribes. Immediately an audit was implemented by the Care Coordinator, to ensure proper documentation and proper administration of medication is provided each shift. Audits are completed once a week by the Care Coordinator. 3/7/25 and on going the Administrator will review the audits weekly, and continue regular in-services/education on the 5 rights of medication administration.

Licensee's Proposed Overall Completion Date: 04/14/2025

Implemented (█ - 05/12/2025)

224a - Preadmission Screen Form

11. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted to the home on █; however, the resident's preadmission screening form was completed on █.

Plan of Correction

Accept (█ - 04/11/2025)

Administrator failed to ensure the proper date was entered when completing the pre admission screening on █ admission. 2/26/25 and ongoing the Administrator will utilize a checklist upon each admission, to ensure the dates are correct in determining the residents needs can be met by the services provided by the home.

224a - Preadmission Screen Form (continued)

Licensee's Proposed Overall Completion Date: 03/27/2025

Implemented () - 05/12/2025

231c - Preadmission Screening

12. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to 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 written cognitive preadmission screening was completed on [redacted]

Plan of Correction

Accept () - 04/11/2025

Administrator failed to ensure the proper date was entered when completing the pre admission screening on [redacted] admission to the SDCU. 2/26/25 and ongoing the Administrator will utilize a checklist upon each admission, to ensure the dates are correct in determining the residents needs can be met by the services provided by the home with in 72 hours.

Licensee's Proposed Overall Completion Date: 03/27/2025

Implemented () - 05/12/2025