

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

August 14, 2025

[REDACTED], ADMINISTRATOR
OUR HOME OF HOPE INC
223-225 CHERRY STREET
COLUMBIA, PA, 17512

RE: OUR HOME OF HOPE
223-225 CHERRY STREET
COLUMBIA, PA, 17512
LICENSE/COC#: 33322

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/16/2025 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: *OUR HOME OF HOPE* License #: 33322 License Expiration: 06/13/2026
 Address: 223-225 CHERRY STREET, COLUMBIA, PA 17512
 County: LANCASTER Region: CENTRAL

Administrator

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

Legal Entity

Name: *OUR HOME OF HOPE INC*
 Address: 223-225 CHERRY STREET, COLUMBIA, PA, 17512
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: 04/14/1994 Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 26 Waking Staff: 20

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: 06/16/2025

Inspection Dates and Department Representative

06/16/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 30 Residents Served: 26
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 17 Are 60 Years of Age or Older: 20
 Diagnosed with Mental Illness: 13 Diagnosed with Intellectual Disability: 2
 Have Mobility Need: 0 Have Physical Disability: 1

Inspections / Reviews

06/16/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: 07/03/2025

07/09/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 08/08/2025
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: 07/16/2025

Inspections / Reviews *(continued)*

07/31/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 08/08/2025

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 08/08/2025

08/14/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 08/08/2025

Reviewer: [REDACTED] Follow-Up Type: Not Required

42s - Privacy

1. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 6/16/25, there were multiple cameras installed throughout the home to include front entrance, side entrance, and the outdoor smoking area. These cameras record. However, there was no signage identifying there is video recording of the home's entrances and exits or the interior corridors leading to entrances and exits. There was also no documentation the residents were informed at admission that these areas are subject to video recording.

There was also a camera located in the men's communal area on second floor that video records. An Agent of the Department was able to view a video recording of resident #1 sitting in the men's lounge area on the second floor on 6/11/25, at approximately 2:00 PM. This video also had a view into a resident's bedroom.

Plan of Correction

Accept (█) - 07/31/2025)

- On 6-16-2025 Maintenance Staff Member immediately changed the position of one camera located in the men's lounge area.
- On 6/19/2025 Maintenance Staff person or designated person on 6/17/2025 placed signage in entrances, exits, and interior corridors where video recording in progress.
- On 6/17/2025 Administrator developed a form to inform all current and new residents at admission about video recording in progress and privacy.
- On 7/5/2025 Administrator met with all residents to read and sign new form on Privacy
- On 7/10/2025 Administrator contacted Camera Security Company and they came out for service call on 7/16/2025 and changed any camera from recording to monitoring in resident privacy areas.
- On 6/17/2025 Administrator will have meetings about on going monitoring started on 6/17/2025 and Maintenance staff will continue monitoring cameras and complete camera audit every six months.
- Administrator will include signage, and form to review at next QA meeting scheduled 7/31/2025.

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

Implemented (█) - 08/14/2025)

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

Staff person █ the home's administrator, completed only 8 hours of Department-approved training in training year 2024.

64c - Annual Training (continued)

Plan of Correction

Accept (█) - 07/31/2025)

- On 6/16/2025 Administrator was educated by inspectors on the requirements of the administrator's annual training.
- On 6/17/2025 Administrator forwarded all Administrator annual training to be reviewed.
- On 6/16/2025 Administrator completed audit and will continue to do quarterly audit on personal file to ensure the administrator has 24 credit hours of continuing education annually and understands the breakdown of requirements and ensure DHS compliance.
- Administrator will include the Staff Audit Training Sheet to be reviewed at next QA meeting scheduled 7/31/2025.

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

Implemented (█) - 08/14/2025)

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 bath rugs in bathrooms near resident rooms #106, #204, and #208 slide on the floor when pressure is applied, creating a fall hazard.

Plan of Correction

Accept (█) - 07/31/2025)

- On 6/16/2025 Designated person immediately removed bath rugs from 106, 204, 208 and replaced with bath rugs with rubber backing to prevent a fall hazard.
- On 6/17/2025 Administrator educated housekeeping staff on the bath rugs in bathrooms to ensure rubber backing is in good condition and free of hazards.
- On 7/9/2025 Administrator or housekeeping person completed evaluate on the condition of bath rugs. An initial audit was completed on 7/9/2025 and will continue quarterly audit checks and will replace bath rugs as needed to ensure good condition and free of hazards.
- Administrator will include quarterly check information to be reviewed at next QA meeting scheduled 7/31/2025.

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

Implemented (█) - 08/11/2025)

103c - Food Protected

4. Requirements

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 6/16/25, at approximately 1:30 PM, freezers #2, #3, and #4 located in the basement had food spillage and crumbs inside the opening of the freezers. The refrigerator and freezer in the kitchen had some spillage and crumbs inside the openings.

103c - Food Protected (continued)

Plan of Correction

Accept (█ - 07/31/2025)

- On 6/16/2025 Cook and designated person immediately wiped food spillage and removed all crumbs from freezers in basement and refrigerator and freezer in the kitchen area.
- On 6/16/2025 Cook or designated person will monitor freezers and refrigerators daily and weekly during the weekly kitchen cleaning.
- On 6/26/2025 Administrator or designated person re- educate staff on Basic Food Handling
- Administrator will include monitoring/ re-education to be reviewed at next QA meeting scheduled 7/31/2025.

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

Implemented (█ - 08/11/2025)

103f - Refrigerator/Freezer Temps

5. 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

On 6/16/25, at 1:20 PM, the temperature in freezer #3 was 28 degrees Fahrenheit, and at 2:45 PM, it was 25 degrees Fahrenheit.

On 6/16/25, at 2:12 PM, the temperature in the freezer in the dining room was 18 degrees Fahrenheit, and at 3:42 PM, it was 8 degrees Fahrenheit.

Plan of Correction

Accept (█ - 07/31/2025)

- On 6/16/2025 Cook and Maintenance person immediately placed thermometers inside the refrigerators and freezers.
- On 6/16/2025 Cook and designated person will continue monitoring freezers and refrigerators daily during daily temperature checks.
- On 6/26/2025 Administrator or designated person re- educate staff on Basic Food Handling.
- Administrator will include monitoring to be reviewed at next QA meeting scheduled 7/31/2025.

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

Implemented (█ - 08/11/2025)

132b - Safety Inspection/Fire Drill

6. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

132b - Safety Inspection/Fire Drill (continued)

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on 5/19/25. The previous fire safety inspection and drill was conducted on 4/30/24.

Plan of Correction

Accept () - 07/31/2025

- On 6/16/2025 Administrator completed audit on current information and found we were four days shy of the grace period.
- Administrator will send out annual letter to fire safety inspection to ensure annual fire drill is completed on or before the previous annual fire drill.
- On 6/17/2025 Administrator educated Maintenance person on Safety Inspection/ Fire Drills to ensure DHS compliance.
- Administrator will audit the annual fire drill log, starting at the beginning of the year.
- Administrator will include annual fire drill log audit to review at next QA meeting scheduled 7/31/2025.

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

Implemented () - 08/11/2025

132e - Fire Drill Sleeping Hours

7. Requirements

2600.

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

Description of Violation

The last fire drill conducted during sleeping hours was on 2/27/25 at 5:30 AM. The previous sleeping hours fire drill was conducted on 3/29/24 at 5:00 AM.

Plan of Correction

Accept () - 07/31/2025

- On 6/16/2025 Administrator completed audit on current information and found that we were off by one month.
- On 6/18/2025 Administrator educated Maintenance person on Frill Drill Sleeping hours, a fire drill shall be held during sleeping hours once every 6 months.
- On 6/17/2025 Administrator and Maintenance person will ensure sleeping fire drills are conducted every six months. On 6/17/2025 adding this to the current monthly audit sheet to ensure DHS compliance.
- On 6/17/2025 Administrator and Maintenance person completed monthly audit sheet and will continue to both sign off on audit review.
- Administrator will include fire drill audits to review at next QA meeting scheduled 7/31/2025.

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

Implemented () - 08/11/2025

141a - Medical Evaluation

8. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

141a - Medical Evaluation (continued)

Description of Violation

Resident #2 was admitted to the home on [REDACTED]. However, the resident's initial medical evaluation was completed on [REDACTED].

Plan of Correction

Accept ([REDACTED] - 07/31/2025)

- On 6/16/2025 Administrator will ensure the medical evaluation(s) is completed within 60 days prior to admission or within 30 days after admission.
- On 6/19/2025 Administrator completed re-education on DHS Regulation Compliance for medical evaluations.
- On 6/17/2025 Administrator completed medical evaluation audit, will continue to monitor/ audit medical evaluation(s) with resident admission audit sheet to ensure DHS compliance
- Administrator will include resident admission audit sheet to review at next QA meeting scheduled 7/31/2025.

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

Implemented ([REDACTED] - 08/11/2025)

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 most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Plan of Correction

Accept ([REDACTED] - 07/31/2025)

- On 6/16/2025 Administrator will ensure the annual medical evaluation is completed on or before the last medical evaluation was completed.
- On 6/17/2025 Administrator completed annual medical evaluation audit, will continue to monitor/ audit annual medical evaluation(s) with resident admission audit sheet to ensure DHS compliance
- On 6/19/2025 Administrator completed re-education on DHS Regulation Compliance for medical evaluations.
- Administrator will include resident admission audit sheet to review at next QA meeting scheduled 7/31/2025.

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

Implemented ([REDACTED] - 08/11/2025)

185a - Implement Storage Procedures

10. 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 #4 is prescribed Naphcon drops and Ondansetron 4 mg as needed. However, on 6/16/25, these medications were not available in the home.

185a - Implement Storage Procedures (continued)*Repeated Violation - 6/12/24, et al***Plan of Correction****Accept (█ - 07/31/2025)**

- On 6/16/2025 Administrator was notified that Naphcon drops medication order was dated 2/30/2022, however new order from PCP was faxed to pharmacy on 6/13/2025 and were not delivered to facility until 6/17/2025. The order was pushed thru E-MAR system without being approved by administrator. All parties are working on issue. (Awaiting Letter from both parties). Prior to 6/16/2025 Ondansetron as needed medication was called and faxed-facility needed a new order or D/C order by PCP and facility was awaiting response from PCP for plan as of 6/16/2025.

- On 6/27/2025 Administrator or designated person completed medication cart audit to ensure all PRN medications are available in the facility.

- On 6/27/2025 Administrator or Clinical Nurse Supervisor LPN added an additional checks to the monthly med cart audit to ensure all PRN medications are available in the facility. Monthly med cart audits will continue as scheduled and completed by Clinical Nurse Supervisor.

- On 7/31/2025 Administrator will review situation will all Med Tech and educate/ re-educate about ensuring all resident meds are in med cart and available if needed.

- Administrator will include med cart audits / re-education training to review at next QA meeting scheduled 7/31/2025.

Licensee's Proposed Overall Completion Date: 07/31/2025**Implemented (█ - 08/14/2025)****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 #2 was admitted to the home on █; however, the resident's preadmission screening form was completed on █

Plan of Correction**Accept (█ - 07/31/2025)**

- On 6/17/2025 Administrator will ensure pre- admission screening are completed within 30 days prior to admission and will continue to maintain compliance.

- On 6/19/2025 Administrator completed re-education on DHS Regulation Compliance for Pre-admission Screen Form.

224a - Preadmission Screen Form (continued)

- On 6/17/2025 Administrator completed pre-admission screening audit, will continue to monitor/ audit Pre-admission screening form with resident admission audit sheet to ensure DHS compliance
- On 6/17/2025 Administrator will continue with resident admission audit sheet to ensure pre- admission screening application paperwork is completed within 30 days and are in DHS compliance.
- Administrator will include resident admission audit sheet to review at next QA meeting scheduled 7/31/2025.

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

Implemented (█) - 08/11/2025)

227g -Support Plan Signatures

12. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3 participated in the development of █ support plan on █. However, the resident did not sign the support plan.

Plan of Correction

Accept (█) - 07/31/2025)

- On 6/17/2025 Clinical Nurse Supervisor LPN visited resident at SNF and had resident sign █ RASP, resident currently resides in Skilled care facility for rehabilitation services.
- On 6/19/2025 Administrator completed initial audit on RASP's to ensure DHS compliance.
- On 6/17/2025 Administrator or Clinical Nurse Supervisor LPN will continue quarterly RASP's audits to ensure on going DHS compliance.
- On 6/17/2025 Administrator will continue with resident admission audit sheet to ensure RASP's are signed and dated by residents.
- Administrator will include resident admission audit sheet to review at next QA meeting scheduled 7/31/2025.

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

Implemented (█) - 08/11/2025)