

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

June 5, 2025

[REDACTED] ED
SOUDERTON MENNONITE HOMES
207 WEST SUMMIT STREET
SOUDERTON, PA, 18964

RE: SOUDERTON MENNONITE HOMES
207 WEST SUMMIT STREET
SOUDERTON, PA, 18964
LICENSE/COC#: 12776

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/24/2025, 03/25/2025 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: SOUDERTON MENNONITE HOMES License #: 12776 License Expiration: 06/20/2025
 Address: 207 WEST SUMMIT STREET, SOUDERTON, PA 18964
 County: MONTGOMERY Region: SOUTHEAST

Administrator

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

Legal Entity

Name: SOUDERTON MENNONITE HOMES
 Address: 207 WEST SUMMIT STREET, SOUDERTON, PA, 18964
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 06/29/2024 Issued By: COPA
 Type: I-1 Date: 11/25/2024 Issued By: COPA

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 122 Waking Staff: 92

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 03/25/2025

Inspection Dates and Department Representative

03/24/2025 - On-Site: [REDACTED]
 03/25/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 154 Residents Served: 99
 Secured Dementia Care Unit
 In Home: Yes Area: Serenata Capacity: 27 Residents Served: 23
 Hospice
 Current Residents: 3
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 99
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 23 Have Physical Disability: 0

Inspections / Reviews

03/24/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/24/2025

Inspections / Reviews (*continued*)

05/05/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 05/25/2025
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/10/2025

05/19/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 05/25/2025
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 05/26/2025

06/05/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 05/25/2025
Reviewer: [REDACTED] Follow-Up Type: Not Required

42c - Treatment of Residents

1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident # 1 reported to feeling intimidated when seeing Staff Member A. Resident # 1 described that when Staff Member A is providing care to the resident the staff member has an attitude while providing care. The resident's diagnosis of [REDACTED] limits their ability to lift their legs onto the bed and Staff Member A requires this resident to lift [REDACTED] legs independently. The resident describes Staff Member has an attitude when the resident is unable to lift their legs independently and requires assistance from staff.

Plan of Correction

Accept ([REDACTED] - 05/19/2025)

1. PCHA and Care Coordinator met with staff member A on 3/31/25 and reviewed expectations of treating all residents with dignity and respect.
2. Online training module in Relias on regulation 42(c) to be assigned to all Personal Care nursing staff, to be completed by 05/25/2025.
3. Starting May 2025, interviews of 5 random residents by Personal Care Social Worker or designee to inquire if they feel they are being treated with dignity and respect. These interviews will be completed monthly for three months or until compliance is achieved and will be presented at monthly QAPI meetings in June, July and August 2025.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented ([REDACTED] - 06/05/2025)

82c - Locking Poisonous Materials

2. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Gojo Green certified foam hand cleanser, with a manufacture's label indicating "if swallowed consult a physician or poison control center", was unlocked, unattended, and accessible to residents in the secured dementia care unit in two public restrooms, across from the salon and across from bedroom 3557. Not all the residents of the home, including all of the residents in the secured dementia care unit, have been assessed capable of recognizing and using poisons safely.

Micro kill bleach germicidal bleach wipes, with a manufacture's label indicating "if swallowed: Rinse mouth with water. Do not give sodium bicarbonate, fruit juices or vinegar. Do not induce vomiting. Call a physician or poison control center immediately. Only induce vomiting at the instruction of medical personnel. Never give anything by mouth to an unconscious person", was unlocked, unattended, and accessible to residents in the secured dementia care unit housekeeping cart across from bedroom 3515. Not all the residents of the home, including all of the residents in the secured dementia care unit, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 4/22/24 et al

Plan of Correction

Accept ([REDACTED] - 05/05/2025)

1. The hand cleanser in the restrooms were removed on 03/25/2025 by the PCHA. The disinfectant wipes on the housekeeping cart were placed in a locked area by the housekeeper on 03/25/2025.

82c - Locking Poisonous Materials (continued)

- 2. Housekeeping staff will receive training by 04/30/2025 on the requirement to keep all poisonous materials inaccessible to memory care residents by Environmental Services Supervisor.
- 3. Starting 04/28/2025 a weekly audit will be conducted by the Housekeeping Supervisor or designee for three months or until compliance is achieved to ensure that all poisonous materials are kept locked and inaccessible to memory care residents .
- 4. Starting 04/28/2025 the Environmental Services Supervisor or designee will perform monthly audits for three months or until compliance is achieved. Any adverse findings to be reported in monthly QAPI meetings by the Director of Plant Operations.

Licensee's Proposed Overall Completion Date: 04/30/2025

Implemented (████) - 06/05/2025)

91 - Telephone Numbers

3. Requirements

2600.

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

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident bedroom 3515.

Repeat Violation: 2/10/25

Plan of Correction

Accept (████) - 05/19/2025)

- 1. Personal Care Social Worker audited all PC rooms on 3/25/25 to ensure emergency numbers were placed by all resident phones.
- 2. Starting May 2025, PCHA or designee will complete monthly audits in 10 random resident rooms to ensure emergency numbers are located on phones with outside lines. These audits will be completed for three months, or until compliance is achieved.
- 3.PCHA will present results of these audits in monthly QAPI meetings for 3 months starting June 2025 or until compliance is achieved.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented (████) - 06/05/2025)

95 - Furniture and Equipment

4. Requirements

2600.

- 95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/24/25 there was a tool cart located across from bedroom 3525. The tool cart was unattended, unlocked, and accessible to residents in the secured dementia care unit. The tool cart contained a hammer, socket wrench, pliers, a drill, a battery for the drill, hard hat, work gloves, a shop vacuum, step ladder, plastic covering, sweatshirt, and iced

95 - Furniture and Equipment (continued)

tea. The box cutter, hammer, and pliers present a safety hazard to those located in the secured dementia care unit.

Plan of Correction

Accept ([redacted]) - 05/05/2025

1. [redacted] Construction established long-term care guidelines that must be followed when working within a personal care facility. These guidelines were reviewed with the [redacted] Construction team members who left the cart unattended by the job site superintendent on 03/31/2025.
2. Starting 3/31/2025 all [redacted] construction team members working in the personal care facility will be required to review the long-term care guidelines and sign off, confirming they reviewed the guidelines and will adhere to the protocols outlined by [redacted]
3. Starting 3/31/2025, when [redacted] team members are working in the personal care facility, a daily audit will be completed by the job site superintendent or designee to ensure compliance.
4. Starting April 1, 2025, these audits will be reviewed by PCHA weekly to ensure compliance.

Licensee's Proposed Overall Completion Date: 04/30/2025

Implemented ([redacted]) - 06/05/2025

100a - Exterior - Free of Hazards

5. Requirements

2600.

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

Description of Violation

The secured dementia care unit has two outdoor courtyards. The outdoor courtyard off the dining room, labeled the private courtyard, has an area off the walking path that is mulched and has a 3 feet drop to a storm drain. This drop is a potential tripping hazard and is only roped off with sticks and a rope. The outdoor courtyard off the living room, labeled the shared courtyard, has 3 mulch areas, off the walking path, that drop to storm drains. The first two drops are about 3 feet and the third drop with the green storm drain drops about 18 inches. All three of these drains are roped off by sticks and a rope and are potential tripping hazards.

Plan of Correction

Accept ([redacted]) - 05/19/2025

1. Temporary orange construction fencing was installed on all four sides of each inlet by [redacted] Construction team members on April 18, 2025.
2. The landscaping in these areas was designed by a landscaping architect. The plans for these areas include bushes and grasses that will form borders and physical barriers to the storm drains. The tentative date for this landscaping work to begin is June 2025.
3. During this time of construction, the doors leading to the courtyards will remain locked and residents will not have access to the courtyards unless they are accompanied by a staff or family member . These doors are locked by a magnetic lock and will release in the event of an emergency.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented ([redacted]) - 06/05/2025

132c - Fire Drill Records

6. Requirements

2600.

132c - Fire Drill Records (continued)

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 record for the drills conducted on 5/7/24, 6/13/24, 7/30/24, 8/14/24, 9/9/24, 10/3/24, and 11/15/24 does not include the different exit routes used, the home only lists "hallways to safe zones".

The fire drill record for the drills conducted on 12/18/24, 1/27/25, 2/20/25, and 3/4/25 does not include the different exit routes used, the home only lists "hallways to stair towers or exits".

Plan of Correction

Accept (█) - 05/19/2025

1. Starting with the May 2025 fire drill specific fire tower and other fire safe zones will be added to the fire drill event documentation by the Director of Environmental Services to identify evacuation routes used during each drill.
2. Starting with the May 2025 fire drill, specific fire tower and other fire safe zones will be added to the fire drill record for all fire drills by PCHA.
3. Starting May 2025, The Director of Environmental Services or designee will perform monthly audits of fire drill event documentation for three months or until compliance is achieved. Any adverse audit findings will be reported in monthly QAPI meetings in June, July and August 2025.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented (█) - 06/05/2025

141a 1-10 Medical Evaluation Information

7. 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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident # 2's medical evaluation, dated (█), does not include medication regimen, contraindicated medications, medication side effects.

Plan of Correction

Accept (█) - 05/19/2025

1. Nurses will receive training on regulation 141a by Care Coordinator in April 2025 staff meeting. Staff members who are not able to attend the staff meeting will be trained individually by Care Coordinator or designee by 05/30/2025.

141a 1-10 Medical Evaluation Information (continued)

- 2. Care Coordinator or designee will audit all DME's by 05/30/2025 to ensure medication information is included.
- 3. Starting May 2025, Care Coordinator or designee will do monthly audit of new admission DME's to ensure compliance with regulation 141a for three months or until compliance achieved .
- 4. PCHA will present audit findings at monthly QAPI meetings in June, July and August 2025.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented () - 06/05/2025

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 # 3 is prescribed Lorazepam 0.5mg 1/2 tablet three times daily by mouth at 8:00 A.M., 4:00 P.M. and 8:00 P.M. On 3/21/25 and 3/22/25 Resident # 3 received all three doses according to the medication administration record. The narcotic control log for Resident # 3 has this medication listed as administered on 3/21/25 at 8:20 A.M. and 3/22/25 at 4:57 P.M., 9:00 P.M., 8:01 P.M., 3:19 P.M., and 7:08 P.M.

Plan of Correction

Accept () - 05/19/2025

- 1. Nurses and med techs will receive training on regulation 185a by Care Coordinator in April 2025 staff meeting. Staff members who are not able to attend the staff meeting will be trained individually by Care Coordinator or designee by 05/30/2025.
- 2. Starting May 1, 2025, Care Coordinator or designee will audit the narcotic logs weekly for three months or until compliance achieved to ensure the date listed matches the electronic medical records.
- 3. PCHA will present audit findings at monthly QAPI meetings in June, July and August 2025.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented () - 06/05/2025

224a - Preadmission Screen Form

9. 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 () - 05/19/2025

- 1. Care Coordinator or designee will audit all resident files by 05/25/2025 to ensure preadmission screenings were completed within 30 days of admission.
- 2. Starting May 2025, Care Coordinator or designee will do monthly audits on all admissions and readmissions to ensure preadmission screenings were completed within 30 days of admission. These audits will be done for three

224a - Preadmission Screen Form (continued)

months or until compliance is achieved.

3. PCHA will present audit findings at monthly QAPI meetings in June, July and August 2025.

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented (████) - 06/05/2025)

225c - Additional Assessment

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 #1's assessment, dated █████, does not include the resident's need for assistance getting in and out of bed. Resident #1 reported that █████ requires assistance to lift their legs to get into bed due due the resident's physical limitations related to a diagnosis of █████. The current RASP indicates that this resident is independent with transferring in/out of bed/chair, ambulating, and turning and positioning in bed/chair.

Plan of Correction

Accept (████) - 05/19/2025)

- 1. On 04/14/2025, Care Coordinator completed a RASP addendum for Resident #1 to include the need for assistance lifting █████ legs into bed .
- 2. Care Coordinator or PCHA will provide education to nursing staff on regulation 225c in April and May 2025 staff meetings. Staff who are unable to attend these meetings will be trained individually by Care Coordinator or PCHA by 05/30/2025.
- 3. Starting 05/01/2025 Care Coordinator or PCHA will review the 72 hour report weekly to audit for significant changes that would warrant a RASP addendum to ensure compliance. These audits will be completed for three months, or until compliance is achieved .

Licensee's Proposed Overall Completion Date: 05/25/2025

Implemented (████) - 06/05/2025)