



October 21, 2019

Mr. Roger Beins, RN, BC, NHA  
COO  
Menno-Haven, Inc.  
2011 Scotland Avenue  
Chambersburg, Pennsylvania 17201

RE: Brookview Personal Care Center  
2075 Scotland Avenue  
Chambersburg, Pennsylvania 17201  
Certificate #: 336710

Dear Mr. Beins:

As a result of the Department's Bureau of Human Services Licensing annual inspection on August 5, 2019 and September 16, 2019 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to [https://www.surveymonkey.com/r/BHSL\\_Inspection](https://www.surveymonkey.com/r/BHSL_Inspection).

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written over a white background.

Kevin Hancock  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Violation Report

## Violation Report

### Facility Information

Name: *BROOKVIEW PERSONAL CARE CENTER*  
Address: *2075 SCOTLAND AVENUE, CHAMBERSBURG, PA 17201*  
County: *FRANKLIN* Region: *CENTRAL*

License Number: *33671*

### Administrator

Name: *Jody Plasterer* Phone: *7172612322* Email: *jody.plasterer@mennohaven.org*

### Legal Entity

Name: *MENNO HAVEN INC*  
Address: *2011 SCOTLAND AVENUE, CHAMBERSBURG, PA, 17201*

### Certificate(s) of Occupancy

Type: *I-1* Date: *02/09/2010* Issued By: *Greene Twp.*

### Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *84* Waking Staff: *63*

### Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*  
Reason: *Renewal*

### Inspection Dates and Department Representative

*08/05/2019 - On-Site: Kellie Cargile, Israel Springs*

### Resident Demographic Data as of Inspection Dates

#### General Information

License Capacity: *130* Residents Served: *84*

#### Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

#### Hospice

Current Residents: *2*

#### Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *84*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *0* Have Physical Disability: *1*

Rec'd  
8/21/19  
GE

85a - Sanitary Conditions

Regulations

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/27/19, at 12:02 pm, Resident #1's glucometer was used to test the blood sugar of Resident #2.  
On 7/28/19, at 7:23 am, Resident #3's glucometer was used to test the blood sugar of Resident #2.

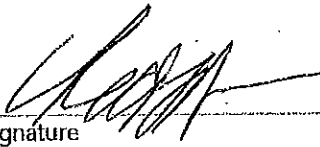
Plan of Correction (POC)

The identified glucometers were immediately disposed of, and the physicians for the identified residents were immediately notified. - GE, 9/16/19

- All Staff were immediately educated on the policy and procedures of documenting and administering insulin and glucascans.
- An Audit was completed and will continue to be done weekly with any discrepancies reported to Administrator, this plan has been initiated immediately. Any discrepancies will result in disciplinary action.
- Staff supervisor will do weekly checks on medication carts and glucascans to ensure proper documentation is being completed.
- A personal care clinical quality coordinator has been hired to monitor documentation, audit charts and to provide ongoing education to all staff.

The findings of the audits will be addressed at the home's next quality assessment meetings. - GE, 9/16/19

Legal Entity Representative



Signature

*Roger L. Beins, Chief Operating Officer 8/21/2019*

Printed Name and Title

Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/16/19  
(Date)

Plan of correction implementation status as of 9/16/19  
(Date)

The above plan of correction was approved by GE  
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

141a - Medical Evaluation

Regulations

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.

Description of Violation


Resident #4, admitted to the home on 10/29/18, did not have a medical evaluation until 12/3/18.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- An audit was completed on February 24,2019 and all medical evaluations were completed at that time if they needed completed. A Second audit was completed on August 12,2019 to ensure compliance.
- A process was developed to notify administrator and staff supervisor when medical evaluations were due to ensure they continue to be completed in a timely manner.
- A personal care clinical quality coordinator has been hired to perform audits of medical evaluations and follow up evaluations will be done at quarterly quality assessment meetings.

Legal Entity Representative

  
Signature

*Ronald B. ...*  
Printed Name and Title 8/21/19  
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/16/19  
(Date)

Plan of correction implementation status as of 9/16/19  
(Date)

The above plan of correction was approved by GE  
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

183f - Discontinued Medications

Regulations

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Lantus 100/ml, prescribed to Resident #2, had a written expiration date of 7/26/19. This medication was located in the home's medication cart and administered daily until 8/5/19.

Centrum Silver, prescribed to Resident #6, was located in the home's medication cart. This medication expired 09/2016.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- An audit was completed immediately throughout all medications to ensure all medications were up to date
- A process was put in place to check all medications weekly for any outdated or not current medications. Any discrepancies will be reported to the administrator .
- A personal care clinical quality coordinator will also do ongoing education/audits to staff on policies and regulations including proper medication administration including not administering expired medications.

Legal Entity Representative

  
Signature

*Recep L. Brins, Chief Operating Officer*  
Printed Name and Title

8/21/19  
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/16/19  
(Date)

Plan of correction implementation status as of 9/16/19  
(Date)

The above plan of correction was approved by GE  
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

185a - Implement Storage Procedures

Regulations

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

Blood sugar readings in the residents' glucometers do not match readings documented on the residents' medication administration records (MARs).

Resident #2:

On 7/31/19, at 11:29 am, a reading of 91 was recorded on the MAR. A blood sugar reading of 97 was on the glucometer.

On 7/23/19, at 4:28 pm, a reading of 126 was recorded on the MAR, A blood sugar reading of 128 was on the glucometer.

Resident #5:

On 7/26/19, at 7:11 am, a reading of 157 was recorded on the MAR. A blood sugar reading of 154 was on the glucometer.

On 7/19/19, at 4:12 pm, a reading of 233 was recorded on the MAR. A blood sugar reading of 232 was on the glucometer.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- All glucascan machine were checked immediately to ensure the correct name of Resident was labeled correctly on each Resident's machine.
- All staff was in-serviced of the correct procedure for documentation of glucometers on MARS.
- Audits will be maintained daily and any further errors will result in disciplinary actions.

The findings of the audits will be addressed at the home's next quality assessment meeting. - GE, 9/16/19

Legal Entity Representative

  
Signature

*Proper L. Beins, Chief Operating Officer* 8/21/19  
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/16/19  
(Date)

Plan of correction implementation status as of 9/16/19  
(Date)

Fully Implemented

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

The above plan of correction was approved by GE  
(Initials)

224a - Preadmission Screen Form

Regulations

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 #4's preadmission screening form, dated 10/7/18, does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident #5 was admitted to the home on 12/27/18. A preadmission screening form could not be located for this resident.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- All charts were audited for preadmission screenings immediately.
- Any charts that were missing preadmission documentation was completed with the current date.
- An audit and follow up will be completed quarterly to ensure documentation is properly completed.

Legal Entity Representative

  
Signature

*Roger L. Beins, Chief Operating Officer* 8/2/19  
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/16/19  
(Date)

Plan of correction implementation status as of 9/16/19  
(Date)

The above plan of correction was approved by GE  
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented