



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: chehn@keystonevillaatdouglassville.com
MAILING DATE: June 1, 2020

Mr. Matthew J. Haydien
Chief Operating Officer
HSL Douglassville Subtenant LLC
C/O Renew Reit ATTN Legal
One Seagate, Suite 1500
Toledo, Ohio 43604

RE: Keystone Villa at Douglassville Personal Care
1152 Ben Franklin Highway East
Douglassville, Pennsylvania 19518
License #: 227680

Dear Mr. Haydien:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 30, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Moskalczyk".

Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *KEYSTONE VILLA AT DOUGLASSVILLE PERSONAL CARE*
Address: *1152 BEN FRANKLIN HIGHWAY EAST, DOUGLASSVILLE, PA 19518*
County: *BERKS* Region: *NORTHEAST*

License Number: *22768*

Administrator

Name: *Carrie Hehn* Phone: *6703852000* Email: *chehn@keystonevillaatdouglassville .com*

Legal Entity

Name: *HSL DOUGLASSVILLE SUBTENANT LLC*
Address: *ONE SEAGATE, SUITE 150Q C/O RENEW REIT ATTN LEGAL, TOLEDO, OH, 43604*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: Issued By:

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *797* Waking Staff: *148*

Inspection

Type: *Partial* BHA Docket #: Notice: *Unannounced*
Reason: *Complaint*

Inspection Dates and Department Representative

03/30/2020 - Off-Site: Amy Deluca

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *168* Residents Served: *131*

Secured Dementia Care Unit

In Home: *Yes* Area: *n/a* Capacity: *68* Residents Served: *47*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *131*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *66* Have Physical Disability: *0*

182b - Prescription Medication

Regulations

2600.182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; *etc.* nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Through staff interview it was determined that treatments for residents such as lotions and creams are dispensed by med techs and assigned to direct care workers for administration. Prescribed medication treatments are being administered to residents by direct care aides who have not completed the required medication administration training.

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.)

What: Through staff interviews, it was determined that treatments for residents, such as lotions and creams, are being dispensed by med techs and assigned to care workers for administration. Prescribed medication treatments are being administered to the residents by direct care aides who have not completed the required medication administration training.

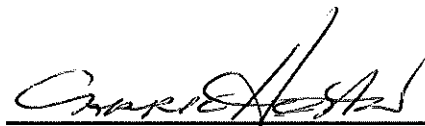
Who: The Resident Care Director and/or designee will re-train the Med Techs regarding the proper administration of medication treatments, such as lotions and creams. (Attachment A)

When: The training of the Med Techs regarding proper administration of medications treatments will be completed by June 11, 2020. The Record of Training will be submitted by June 12, 2020. (Attachment B)

How: The Resident Care Director and/or designee will periodically monitor the administration of medication treatments by the Med Techs to ensure the proper medication administration procedures are being followed.

Ongoing: The Resident Care Director and/or designee will complete monthly QA audits. All findings will be reviewed in the quarterly QA Meetings. (Attachment C)

Legal Entity Representative



Signature

CARRIE HETH, ^{INTERIM} EXECUTIVE ^{05/13/2020}
DIRECTOR Date

Printed Name and Title

Date

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

The above plan of correction is approved as of	5-20-2020	Plan of correction implementation status as of	5-20-2020
	(Date)		(Date)
		<input checked="" type="checkbox"/> Implemented	
The above plan of correction was approved by	MM	<input type="checkbox"/> Not Implemented	
	(Initials)		

182c - Medication Administration

Regulations

2600.182.C Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

Through staff interview it was determined that med techs are dispensing prescribed treatments such as lotions and creams into cups and the cups are assigned to direct care workers to administer. The prescribed treatments are recorded as administered by med techs based on the med techs seeing that the cups with the prescribed treatments were removed from the med cart.

Also, on 3/25/20 the medication Depakote was placed in applesauce for resident #1 by staff person A at dinner and placed on the table for the resident to eat. Resident #2 took the applesauce and ate it, thereby consuming resident #1's medication. Staff person A did not follow all proper steps of medication administration.

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.)

What: Through staff interviews, it was determined that med techs are dispensing prescribed treatments, such as lotions and creams, into cups and the cups are assigned to direct care workers to administer. The prescribed treatments are recorded as administered by the med techs based on the med techs seeing that the cups with the prescribed treatments were removed from the med cart. Also, on 03/25/2020, the medication Depakote was placed in applesauce for Resident #1 by Staff Person A at dinner and placed on the table for the resident to eat. Resident #2 took the applesauce and ate it, thereby consuming Resident #1's medication. Staff Person A did not follow all proper steps of medication administration.

Who: The Resident Care Director and/or designee will re-train the Med Techs regarding the steps identified for proper administration of medications and treatments as defined in regulation 182c. (Attachment D)

When: The training of the Med Techs regarding following the identified steps for proper administration of medications and treatments will be completed by June 11, 2020. The Record of Training will be submitted by June 12, 2020. (Attachment B)

How: The Resident Care Director and/or designee will periodically monitor the administration of medication treatments by the Med Techs, in addition to the bi-annual Medication Observations completed by the Medication Technician Trainer, to ensure the proper medication administration procedures are being followed. (Attachment E).

Ongoing: The Resident Care Director and/or designee will complete monthly QA audits. All findings will be reviewed in the quarterly QA Meetings. (Attachment C)

Legal Entity Representative



Signature

CARRIE HEHN ^{INTERIM} EXECUTIVE 05/13/2020
Printed Name and Title DIRECTOR Date

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

The above plan of correction is approved as of 5-20-2020 (Date) Plan of correction implementation status as of 5-20-2020 (Date)

Implemented

The above plan of correction was approved by MM (Initials) Not Implemented

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #1's medication administration record for March 2020 shows that the following medications were not initialed as administered on the dates and times listed:

- Diltiazem was not administered on 3/15/20 and 3/29/20
 - Divalprox was not administered on 3/15/20 in the morning or in the evening.
 - Divalprox was not administered on 3/30/20 in the morning
 - Lisinopril was not administered on 3/15/20 or 3/29/20 in the morning.
 - Levothyroxin was not administered on 3/16, 3/19, 3/20, 3/23, 3/24, 3/26, 3/29, and 3/31.
- The notes in the MAR do not indicate why the medication was not administered.

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.)

What: Resident #1's medication administration record for March 2020 shows that the following medications were not initialed as administered on the dates/times listed: Diltiazem was not administered on 03/15/2020 and 03/29/2020. Divalprox was not administered on 03/15/2020 in the morning or in the evening. Divalprox was not administered on 03/30/2020 in the morning. Lisinopril was not administered on 03/15/2020 or 03/29/2020 in the morning. Levothyroxin was not administered on 03/16, 03/19, 03/20, 03/23, 03/24, 03/26, 03/29 and 03/31/2020. The notes in the MAR do not indicate why the medications were not administered.

Who: The Resident Care Director and/or designee will re-train the Med Techs on the use of the electronic MAR system, specifically with regards to the proper documentation of administration of medications in a timely manner.

When: The training of the Med Techs regarding proper documentation of administration of medications treatments will be completed by June 11, 2020. The Record of Training will be submitted by June 12, 2020. (Attachment B)

How: The Resident Care Director and/or designee will periodically complete MAR reviews, in addition to the bi-annual MAR reviews completed by the Medication Technician Trainer, to ensure documentation of medication administration is being completely properly. (Attachment F)

Ongoing: The Resident Care Director and/or designee will complete monthly QA audits. All findings will be reviewed in the quarterly QA Meetings. (Attachment C)

Legal Entity Representative



Signature

CARRIE HETH INTERIM EXECUTIVE DIRECTOR 05/13/2020

Printed Name and Title Date

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

The above plan of correction is approved as of 5-20-2020 (Date) Plan of correction implementation status as of 5-20-2020 (Date)

The above plan of correction was approved by MM (Initials) Implemented Not Implemented