

Department of Human Services  
Bureau of Human Service Licensing

July 19, 2021

[REDACTED]  
HSL DOUGLASSVILLE SUBTENANT LLC  
765 SKIPPACK PIKE, SUITE 300  
C/O HERITAGE SENIOR LIVING  
BLUE BELL, PA 19422

RE: KEYSTONE VILLA AT  
DOUGLASSVILLE PERSONAL CARE  
1152 BEN FRANKLIN HIGHWAY  
EAST  
DOUGLASSVILLE, PA, 19518  
LICENSE/COC#: 22768

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/21/2020, 01/25/2021, 05/10/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
Anne Graziano

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services  
Bureau of Human Service Licensing  
LICENSING INSPECTION SUMMARY**

**Facility Information**

Name: *KEYSTONE VILLA AT DOUGLASSVILLE PERSONAL CARE* License #: *22768* License Expiration Date: *06/13/2021*  
Address: *1152 BEN FRANKLIN HIGHWAY EAST, DOUGLASSVILLE, PA 19518*  
County: *BERKS* Region: *NORTHEAST*

**Administrator**

Name: [REDACTED] Phone: *6103852000* Email: [REDACTED]

**Legal Entity**

Name: *HSL DOUGLASSVILLE SUBTENANT LLC*  
Address: *765 SKIPPACK PIKE, SUITE 300, C/O HERITAGE SENIOR LIVING, BLUE BELL, PA, 19422*  
Phone: *6103852000* Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *04/12/1989* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *140* Waking Staff: *105*

**Inspection**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Complaint* Exit Conference Date: *05/10/2021*

**Inspection Dates and Department Representative**

*12/21/2020 - On-Site:* [REDACTED]  
*01/25/2021 - Off-Site:* [REDACTED]  
*05/10/2021 - Off-Site:* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *168* Residents Served: *95*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *NA* Capacity: *68* Residents Served: *41*

**Hospice**

Current Residents: *4*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *94*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *45* Have Physical Disability: *0*

## Inspections / Reviews

12/21/2020 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/17/2021*

6/17/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *06/24/2021*

7/19/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

## 187a - Medication Record

**1. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

**Description of Violation**

*Resident #1 was prescribed Warfarin one 6 mg dose at bedtime and an additional 2 mg dose at bedtime on the days ordered to be administered. However, their Medication Administration Record for October 2020 listed Warfarin 2 mg at bedtime 6 separate times on the days ordered and Warfarin 6 mg at bedtime 2 separate times on the days ordered. Each entry on the MAR for Warfarin was initialed by staff that it was administered.*

**Plan of Correction****Accept**

*What: Resident #1 moved into the community with supratherapeutic INR concerns on [REDACTED] 2020. [REDACTED] blood work was monitored weekly by [REDACTED] physician, including regular dosage adjustments based on the ordered blood work. The community's investigation showed that the resident consistently received the medication in keeping with the physician's orders. Packing slips from the pharmacy matched the quantity of the doses actually administered, as only a one-week supply of each medication order was delivered, relative to the ongoing adjustments. As noted in the violation specific to 187.a, the community failed to take immediate steps to correct the duplicate orders that came through the electronic medication administration system. Staff erroneously signed off on the duplicate orders instead of alerting the pharmacy to the problem.*

*Who: The community's med trainer, [REDACTED] and Resident Care Director, [REDACTED], LPN will coordinate retraining of all staff providing medication administration assistance to our residents on the following:*

- 1. Proper procedures for approving orders*
- 2. How to identify duplicate orders should they occur*
- 3. Proper procedures including immediately notifying the pharmacy, and community supervisors of a possible problem, such as a duplicate order as was the case here.*

*When: Training will be completed by July 9, 2021. Documentation of the training will be provided to the bureau shortly after all team members have completed said training.*

*Ongoing: The community transitioned to a new pharmacy in April of 2021. Since that time, no such problems have been noted. In addition, the new pharmacy will be conducting quarterly MAR-cart audits, with results presented to the Nursing and QA teams, to be reviewed at the next Quarterly QA meeting. Weekly medication cart audits also continue as part of the ongoing QA Best Practices program as well.*

**Completion Date:** 07/09/2021

**Update - 06/17/2021**

*Upon resubmission of the Plan of Correction (POC) the home will submit documentation of training via the Portal.*

AG, 6-17-21

**Document Submission****Implemented**

*Please see Attachment A for Record of Staff Training.*

## 187a - Medication Record (continued)

**Update - 07/19/2021***verifications submitted 6-24-21**on site verification 7-15-21*

AG

## 187d - Follow Prescriber's Orders

**1. Requirements**

2600.

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

**Description of Violation**

*Resident #1 is prescribed 2mg of warfarin for October on 1, 4, 5, 8, 9, 12, 13, 16, 17, 20 and 21 along with 6mg of warfarin equaling 8mg. Resident #1's medication administration record indicated that the resident did not receive the 2mg of warfarin on 10/1/20 but received the 2mg on October 2, 3, 4, 6, 8, 9, 13, 15, 16, 17, 18, 19, 20, 21. The resident's INR was 3.3 on October 1, 2020 and 10.4 on October 21, 2020. On 10/21/20 resident #1 was sent to the hospital where resident #1 passed away due to [REDACTED].*

**Plan of Correction****Accept**

*What: Resident #1 moved into the community with supratherapeutic INR concerns on [REDACTED]/2020. [REDACTED] blood work was monitored weekly by [REDACTED] physician, including regular dosage adjustments based on the ordered blood work. The community's investigation showed that the resident consistently received the medication in keeping with the physician's orders. Packing slips from the pharmacy matched the quantity of the doses actually administered, as only a one-week supply of each medication order was delivered, relative to the ongoing adjustments. As noted in the violation specific to 187.a, the community failed to take immediate steps to correct the duplicate orders that came through the electronic medication administration system. Staff erroneously signed off on the duplicate orders instead of alerting the pharmacy to the problem. Though it appeared to be a medication administration error, the investigation showed it was a medication documentation error.*

*Who: The community's med trainer, [REDACTED] and Resident Care Director, [REDACTED], LPN will coordinate retraining of all staff providing medication administration assistance to our residents on the following:*

- 1. Proper procedures for approving orders*
- 2. How to identify duplicate orders should they occur*
- 3. Proper procedures including immediately notifying the pharmacy, and community supervisors of a possible problem, such as a duplicate order as was the case here.*

*When: Training will be completed by July 9, 2021. Documentation of the training will be provided to the bureau shortly after all team members have completed said training.*

*Ongoing: The community transitioned to a new pharmacy in April of 2021. Since that time, no such problems have been noted. In addition, the new pharmacy will be conducting quarterly MAR-cart audits, with results presented to the Nursing and QA teams, to be reviewed at the next Quarterly QA meeting. Weekly medication cart audits also continue as part of the ongoing QA Best Practices program as well.*

**Completion Date: 07/09/2021**

**187d - Follow Prescriber's Orders (continued)****Update - 06/17/2021**

*Upon Resubmission of the POC, the home will submit evidence of compliance regarding the training of staff and the auditing of med carts to assure that medications on hand match dr orders. The home will also indicate actions taken for any findings outside of expectations during the med audits conducted since the date of implementation of this POC.*

*Any QA meeting held since the investigation will also be submitted to review.*

*Responses and verification documents are to be submitted via the Portal.*

*AG, 6-17-21*

*AG, 6-17-21*

**Document Submission****Implemented**

*Please see Attachment A for Record of Staff Training, Attachment B for Weekly Med Cart Audits (5 Carts) since POC implemented on 06/17/2021 and Attachment C for QA Minutes from QA Meeting Quarter 1 for 2021 on 04/20/2021.*

**Update - 07/19/2021**

*verifications submitted 6-24-21*

*on site verification 7-15-21*

*AG*