Department of Human Services
Bureau of Human Service Licensing

June 4, 2021

[redacted], COO
HSL DOUGLASSVILLE SUBTENANT LLC
ONE SEAGATE, SUITE 1500
C/O RENEW REIT ATTN LEGAL
TOLEDO, OH 43604

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 04/05/2021, 04/06/2021, 04/09/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk
Human Services Licensing Supervisor

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* **Licen e #**: *22768* **Licen e Expiration Date**: *06/13/2021*
Addre : *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: *ONE SEAGATE, SUITE 1500, C/O RENEW REIT ATTN LEGAL, TOLEDO, OH, 43604*
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**: *127* **Waking Staff**: *95*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Rea on: *Renewal* **Exit Conference Date**: *04/09/2021*

Inspection Dates and Department Representative

04/05/2021 - On-Site: [redacted]
04/06/2021 On Site [redacted]
04/09/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *168* **Re ident Served**: *91*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *0* **Capacity**: *68* **Residents Served**: *36*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *90*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *36* **Have Physical Disability**: *0*

Inspections / Reviews

04/05/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *05/15/2021*

5/26/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/02/2021*

6/4/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] Resident #10 was observed in the hallway with blood on [redacted] hands and clothes. [redacted] was sent to the ER and admitted. The home did not report this incident until [redacted]

On 12/8/20, the home discovered that Resident #1, Resident #2, and Resident #3 missed medications. It was not reported to the Department until 12/10/20.

16c - Written Incident Report *(continued)*

Plan of Correction **Accept**

What: Item #1: During the annual survey, the bureau identified that the community did not report an incident that occurred with resident #10 on [redacted] *until* [redacted]
Who: The resident had been sent to the hospital for treatment and evaluation post fall. The community's Interim Executive Director submitted the report once substantial information had been obtained to report.
When: The Incident Reporting Form was submitted to DHS on [redacted]
How: The Incident Reporting Form was submitted per the required bureau reporting methods.
Ongoing: The community will provide reports to the bureau, including verbal reports, within 24 hours in keeping with regulation. The community will provide follow up reports to the bureau, as needed. Submitted Incident Reporting Forms to BHSL will be reviewed as part of the quarterly Quality Assurance program. Findings will be reviewed as part of the QA Audits, and results will be reviewed at the quarterly QA meetings.
What: Item #2: During the annual survey, the bureau identified that the community did not report medication errors n a timely manner that occurred with three residents on 12/8/2020. These reports were submitted to the bureau on 12/10/2020.
Who: The community's Resident Care Director identified the potential that the medications identified may have been a med error. In working with the community pharmacy, it was determined that the medication noted required a new prescription. A narcotic, as is the case here, requires a new prescription to maintain the active stature of the order. There was a delay in the prescriber providing the new order which prompted the delay in the continuance of the order, resulting in the corresponding order being no longer active.
Staff were retrained on proactively identifying orders that may be expiring to allow the team overall to have the time necessary to work with the provider to obtain orders as directed.
When: The community immediately worked with the pharmacy and the EMAR provider to identify options to identify these as potential med errors. The community has also begun working with the providers to proactively execute orders specific to narcotic medications to ensure that, should the order be expected to continue, the provider will provide the appropriate order. All community providers will be contacted on or before July 31, 2021 to provide training on this initiative. At the community level, the Medication Technicians and Nurses are notating on the medication cards the date of the reorder. Medications are being reordered at least 8 days in advance of needing them. The Medication Technicians and Nurses are following up with the pharmacy after each delivery to check the status of the reorder and provide the pharmacy with assistance in contacting the provider for the signed prescription.
How: The community will have nursing and administrative staff work with providers to help ensure that that this resident support need is applied consistently. Administrative staff will make this part of their regular contact to help with new providers/new provider staff as well.
Ongoing: Submitted Incident Reporting Forms to BHSL will be reviewed as part of the quarterly Quality Assurance program, as well as updates regarding the medication reordering process. Findings will be reviewed as part of the QA Audits, and results will be reviewed at the quarterly QA meetings, to ensure any patterns or trends are reported and addressed.

Completion Date: *05/15/2021*

Update - 05/24/2021

Please send/Attach proof of staff training. 5-26-2021 -MM

Document Submission **Implemented**

Please see Attachment E for the Staff Training Records and Copy of the new pharmacy prescription form that was the focus of the training.

42c - Treatment of Residents

1. Requirements

2600.

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

Description of Violation

On 3/5/21, Staff B was providing care to Resident #8. Resident #8 resides in the Secured Dementia Care Unit. Resident #8 was agitated, and Staff B was witnessed by Staff C and Staff D arguing and yelling curse words at Resident #8.

Plan of Correction **Accept**

What: During the annual survey, the bureau investigated a report that the community submitted specific to an ncident involving a staff person and a resident. The bureau concluded that the resident's right to be treated with dignity and respect was violated.
Who: The incident was reported to the community by both community staff and an outside caregiver that staff person B has raised [redacted] voice and used profanity while providing care to resident #8. The community's Associate Executive Director immediately suspended staff person B pending the outcome of the investigation and upon direction from the bureau and Berk's County Area Agency on Aging.
When: The report as outlined in the "Who" section above commenced at 8:40 AM on 3/6/21. This included a verbal, and written, report to the Berk's County Area Agency on Aging as well the bureau within hours of the incident. It should be noted that staff person B was later terminated by the community.
How: The community will continue to provide staff training to include resident rights, our mission and culture and challenging behaviors. Staff will be encouraged to share ideas and suggestions for techniques that prove helpful in supporting residents with challenging behaviors and/or needs during staff meetings and trainings. The community will provide support to the staff at large to ensure that any suspected or witnessed violations related to 2600.42 are reported to the appropriate community staff.
Ongoing: Staff training, including resident rights, mission and culture and challenging behaviors, will be reviewed as part of the quarterly Quality Assurance program. Findings will be reviewed as part of the QA Audits, and results will be reviewed at the quarterly QA meetings.

Completion Date: *05/15/2021*

Update - 05/24/2021

Please send/Attach proof of staff training. 5-26-2021-MM

Document Submission **Implemented**

Please see Attachment F for the copy of Staff Person B's training records and a copy of the New Hire Orientation Training Record.

103c - Food Protected

1. Requirements

2600.

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

Description of Violation

On 4/9/21, there was a tray of peaches and a tray of pie uncovered in the Memory Care Kitchen refrigerator.

103c - Food Protected *(continued)*

Plan of Correction **Accept**

What: During the annual survey, the Licensing Representative found a tray of peaches and pie prepared for service, which was uncovered in a closed refrigerator.
Who: Staff working in the kitchen were made aware of the food items in question and immediately covered the trays prior to service.
When: Upon receiving direction from the Licensing Representative, the staff immediately placed a film of plastic wrap over the trays, which also identified the date and item. This was not removed until the items were served to the residents.
How: The dining staff have been trained on appropriate ways to cover food awaiting presentation to the community's residents. This training occurred via verbal instructions the day of the incident. Supervisors and all community staff will monitor food service venues to ensure that proper procedures related to covering food awaiting service are in place and implemented regularly.
Ongoing: All kitchen and dining staff were re-educated regarding proper storage and identification practices for food items being held for service. This was be completed between 05/09/2021 - 05/14/2021 (Attachment A).

Completion Date: *05/15/2021*

Update - 05/24/2021

Please send/Attach proof of staff training. 5-26-2021 - MM

Document Submission **Implemented**

Please see Attachment A for copy of staff training record.

103f - Refrigerator/Freezer Temps

1. **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

There was no thermometer in the ice cream freezer located in the 2nd floor dining room.

Plan of Correction **Accept**

What: During the annual survey, the Licensing Representative discovered that an ice cream freezer did not have a thermometer.
Who: Staff were notified of the missing thermometer and immediately added a new thermometer to the ice cream freezer in question. It should be noted that the temperature was found to be within normal limits.
When: Immediately, upon discovery
How: Staff will monitor all refrigeration units to ensure that thermometers are in place (Attachment B).
Ongoing: The routine checks of thermometers and respective temperatures will be reviewed as part of the quarterly Quality Assurance program. Findings will be reviewed as part of the QA Audits, and results will be reviewed at the quarterly QA meetings, to ensure any patterns or trends are reported and addressed.

Completion Date: *05/15/2021*

Update - 05/24/2021

103f - Refrigerator/Freezer Temps *(continued)*

Document Submission **Implemented**

Please see Attachment B for thermometer record.

103i - Outdated Food

1. **Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

In the Memory care dining room refrigerator, there was a container of thickened orange juice that was not labeled with a date.

Plan of Correction **Accept**

What: During the annual survey, the Licensing Representative found a container of thickened orange juice in a refrigerator which was not dated or identified.
Who: The dining team confirmed that the product was in fact Pureed Peaches which was prepared for service during lunch and was scheduled to commence a few minutes after the discovery was made. The item was removed and replaced with an appropriately labeled container.
When: Immediately upon discovery
How: Dining staff will follow proper identification and dating procedures for all food items regardless of how quickly they will be served. This naturally does not include items that are in process of preparation. All dietary staff were re-educated on this regulation and proper procedures for storage and identification between 05/09/2021 – 05/14/2021. (Attachment A)
Ongoing: As part of ongoing dietary services audits, food items will be checked for labels to identify the item and date them to ensure nothing is outdated. These audits will be reviewed as part of the ongoing Quality Assurance program and the results will be reported and reviewed at quarterly QA meetings

Completion Date: *05/15/2021*

Update - 05/24/2021

Document Submission **Implemented**

Please see Attachment A for staff training record.

144c1 - Smoking Area Guidelines

1. **Requirements**

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

Description of Violation

Numerous cigarette butts were located on the ground near the curb in the smoking area.

144c1 - Smoking Area Guidelines *(continued)*

Plan of Correction **Accept**

What: During the annual survey, the bureau visited the community smoking area and found two cigarette butts on the ground near the urn used for extinguishing these items.
Who: Staff removed the two cigarette butts.
When: Immediately
How: Staff will monitor this area to ensure that cigarette butts are disposed of properly.
Ongoing: The routine monitoring of the smoking area will be reviewed as part of the quarterly Quality Assurance program. Findings will be reviewed as part of the QA Audits and results will be reviewed at the quarterly QA meetings, to ensure any patterns or trends are reported and addressed.

Completion Date: *05/15/2021*

Update - 05/24/2021

Document Submission **Implemented**

No attachment.

182c - Medication Administration

1. **Requirements**

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
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).

Description of Violation

On 3/18/21, Staff A did not follow proper medication administration procedures when [redacted] placed the medication on the resident #9's table instead of in [redacted] hand. The resident was in the bathroom, so [redacted] medications were left on the table and the staff left the room.

182c - Medication Administration *(continued)*

Plan of Correction **Accept**

What: During the annual survey, the bureau investigated a report that the community submitted on March 19, 2021 specific to an incident involving a medication error. The report that the community submitted had found that the medication technician had left a container of medications on a resident s kitchen table instead of observing them being taken by the resident.
Who: As the report indicated, the Resident Care Director followed procedure and contacted the resident s physician and received no new orders. The mediation technician was removed from the scheduled until retraining on the 5 rights of medication administration including the step of observation of the resident taking the medication was provided. The medication technician was reinstated to this role on 04/12/2021, after the community medication trainer completed the training on 04/01/2021. See the attached retraining documentation (Attachment C).
When: Immediately upon discovering the error the following day.
How: The community will continue to report medication errors, such as this, in a timely manner to the bureau. The community will also continue to follow state guidelines related to certifying and recertifying all medication technicians. This includes remedial training as needed.
Ongoing: Medication errors will be reviewed as part of the Quality Assurance Program. Findings will be reviewed as part of the QA Audits and results will be reviewed at the quarterly QA meetings, to ensure any patterns or trends are reported and addressed.

Completion Date *05/15/2021*

Document Submission **Implemented**

Please see Attachment C for staff retraining documentation.

183b - Meds and Syringes Locked

1. **Requirements**

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 3/18/21 at 8:00PM, Mirtazapine 30mg and Mucus relief 600mg was unlocked, unattended, and accessible in resident #9's room.

183b - Meds and Syringes Locked *(continued)*

Plan of Correction **Accept**

What: During the annual survey, the bureau investigated a report that the community submitted on March 19, 2021 specific to an incident involving a medication error. The report that the community submitted had found that the medication technician had left a container of medications on a resident s kitchen table instead of observing them being taken by the resident, thus leaving the medications unlocked, unattended and accessible in the resident s apartment.

Who: As the report indicated, the Resident Care Director followed procedure and contacted the resident s physician and received no new orders. The mediation technician was removed from the scheduled until retraining on the 5 rights of medication administration including the step of observation of the resident taking the mediation was provided. The medication technician was also provided with retraining on the medication cart to include the securing of all medications. The medication technician was reinstated to this role on 04/12/2021, after the community medication trainer completed the training on 04/01/2021. See the attached retraining documentation (Attachment C).

When: Immediately upon discovering the error the following day.

How: The community will continue to report medication errors, such as this, in a timely manner to the bureau. The community will also continue to follow state guidelines related to certifying and recertifying all medication technicians. This includes remedial training as needed.

Ongoing: Medication errors will be reviewed as part of the Quality Assurance Program. Findings will be reviewed as part of the QA Audits and results will be reviewed at the quarterly QA meetings, to ensure any patterns or trends are reported and addressed.

Completion Date *05/15/2021*

Document Submission **Implemented**

Please see Attachment C for staff retraining documentation.

184a - Labeling OTC/CAM

1. **Requirements**

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

There was a box of salonpas patches in the medicine cart. The medication did not have a pharmacy label or a residents name on it, indicating which resident the medication was for.

184a - Labeling OTC/CAM *(continued)*

Plan of Correction **Accept**

What: During the annual survey, the Licensing Representative identified an over the counter medication, provided by the resident's family, was not properly labeled.
Who: The over the counter medication was removed and a correctly labeled supply was ordered from the community pharmacy and received later that day. No other such medications were found.
When: Immediately upon discovering the incorrectly labeled item.
How: Nurses and Med Techs will continue to check the labels of newly delivered medications to ensure they are correct. Medication cart audits will continue to be completed no less than weekly to ensure all medications are properly labeled. Families who wish to provide medications will be reminded of the need to provide medications with correct labels and the option to obtain medications through our community pharmacy.
Ongoing: The medication cart audits will be reviewed as part of the ongoing Quality Assurance program. Any concerns, trends, patterns, and findings will be reported and discussed at the quarterly QA meetings.

Completion Date: *05/15/2021*

Document Submission **Implemented**

No attachment.

185a - Implement Storage Procedures

1. **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, 5, and 6's glucometers were not calibrated to the correct date and time.

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #7 – On 4/1/21 the reading on the glucometer was 172 but was incorrectly transcribed as 176. On 4/4/21, resident #5's reading on [redacted] *glucometer was 203 but was incorrectly transcribed as 204.*

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

What: During the annual survey, the Licensing Representative found that three resident glucometers were not calibrated to the correct date and time. This resulted in not accurately transferring the blood sugar readings to the EMAR system. It should be noted the deviations did not result in any medication errors.
Who: The three resident glucometers were recalibrated on the day of discovery. Medication technicians and nursing team members were retrained on the proper procedures related to recording blood sugar results in the community EMAR system. This training was completed by [redacted], Medication Technician Trainer, and [redacted] Resident Care Director.
When: Immediately upon discovering the error the following day. The training noted in "Who" above occurred on 04/22/2021. (Attachment D)
How: The nursing team, including the medication technicians, have also been retrained on the auditing of blood sugar results at the beginning of their shifts to ensure any possible transcription errors are identified and corrected. The nurse supervisors or designees will audit blood sugar records during their routine cart audits.
Ongoing: Reviews of cart audits will be completed as part of the ongoing Quality Assurance program. Findings, patterns, trends, and concerns will be reported and reviewed at the quarterly QA meetings.

Completion Date: *05/15/2021*

Document Submission **Implemented**

Please see Attachment D for staff training record.

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident #9 is prescribed Mirtazapine 30mg at bedtime for depression and Mucus relief 600mg every 12 hours for congestion.. However, resident #9 was not administered these medications on 3/18/21 at 8:00pm.

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction **Accept**

What: During the annual survey, the bureau investigated a report that the community submitted on March 19, 2021 specific to an incident involving a medication error. The report that the community submitted identified that the medication technician had left a container of medications on a resident's kitchen table instead of observing them being taken by the resident.
Who: As the report indicated, the Resident Care Director followed procedure and contacted the resident's physician and received no new orders. The mediation technician was removed from the schedule until retraining on the 5 rights of medication administration including the step of observation of the resident taking the mediation was provided. The medication technician was reinstated to this role on 04/12/2021 after the community medication trainer completed the training on 04/01/2021. See the attached retraining documentation (Attachment C).
When: Immediately upon discovering the error the following day.
How: The community will continue to report medication errors, such as this, in a timely manner to the bureau. The community will also continue to follow state guidelines related to certifying and recertifying all medication technicians. This includes remedial training as needed.
Ongoing: Medication errors will be reviewed as part of the Quality Assurance Program. Findings will be reviewed as part of the QA Audits and results will be reviewed at the quarterly QA meetings, to ensure any patterns or trends are reported and addressed.

Completion Date: *05/15/2021*

Document Submission **Implemented**

Please see Attachment C for staff retraining documentation.