

Department of Human Services  
Bureau of Human Service Licensing

September 2, 2021

ADMINISTRATOR

RE: PHOEBE BERKS VILLAGE  
1 READING DRIVE  
WERNERSVILLE, PA, 19565  
LICENSE/COC#: 20536

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/13/2021, 07/14/2021, 07/15/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
[REDACTED]

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: *PHOEBE BERKS VILLAGE* License #: *20536* License Expiration Date: *07/30/2022*  
Address: *1 READING DRIVE, WERNERSVILLE, PA 19565*  
County: *BERKS* Region: *NORTHEAST*

**Administrator**

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

**Legal Entity**

[REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *06/09/1994* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *104* Total Daily Staff: *208* Waking Staff: *156*

**Inspection**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal* Exit Conference Date: *07/15/2021*

**Inspection Dates and Department Representative**

07/13/2021 - On-Site: [REDACTED]  
07/14/2021 - On-Site: [REDACTED]  
07/15/2021 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *91* Residents Served: *78*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *n/a* Capacity: *25* Residents Served: *25*

**Hospice**

Current Residents: *0*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *78*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *26* Have Physical Disability: *3*

Inspections / Reviews

07/13/2021 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/20/2021*

8/18/2021 - POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/25/2021*

9/2/2021 - Document Submission

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

226a - Mobility Assessment

1. Requirements

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #1's assessment, dated [REDACTED] does not include an assessment of the resident's mobility needs.

Plan of Correction

Accept

Resident #1's assessment, dated [REDACTED] was corrected, please see the attached corrected documents.

All current resident's assessments were audited for missing information and corrected by 8/16/2021. Starting 8/16/2021 the day shift nurse is responsible for completing or updating RASPs and DMEs. The day shift nurse will leave the documents in a folder for review each night by the night shift nurse. The night shift nurse will audit them for missing or incorrect information and they will be corrected immediately. After audits and corrections are done the assessments will be filed in the resident's medical chart.

Completion Date: 08/16/2021

Update - 08/18/2021

Attachments are reviewed and approved in Step 2. please send a copy of an audit for 226a with Step 2.

[REDACTED] 8-18-21

Document Submission

Implemented

Audit document attached 8/19/21 [REDACTED]

Update - 09/02/2021

documents reviewed, 9-2-21, [REDACTED]

227d - Support Plan Medical/Dental

1. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The "Personal Care Need and Degree" section of Resident #1's assessment, dated [REDACTED] was not completed to indicate the following: "Caring for personal possessions"; "Writing correspondence"; "Engaging in social and leisure activities"; "Obtaining clean, seasonal clothing." It was also not completed to indicate the resident's "Assessment - Supervision."

Resident #2's RASP, dated [REDACTED] was not completed to indicate "Part III: Summary and Determination."

227d - Support Plan Medical/Dental (continued)

Plan of Correction

Accept

Resident #1's assessment, dated [redacted], was corrected, please see the attached corrected documents. Resident #2's assessment, dated [redacted] was corrected, please see attached corrected documents.

All current resident's assessments were audited for missing information and corrected by [redacted]. Starting [redacted] the day shift nurse is responsible for completing or updating RASPs and DMEs. The day shift nurse will leave the documents in a folder for review each night by the night shift nurse. The night shift nurse will audit them for missing or incorrect information and they will be corrected immediately. After audits and corrections are done the assessments will be filed in the resident's medical chart.

Completion Date: 08/16/2021

Update - 08/18/2021

Attachments are reviewed and approved in Step 2.

Please send in a copy of an audit with Step 2. The audit should show work with corrections or action taken, if warranted.

[redacted] 8-18-21

Document Submission

Implemented

Audit document attached 8/19/21 [redacted]

Update - 09/02/2021

Documents reviewed 9-2-21, [redacted]

227g -Support Plan Signatures

1. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's RASP, dated [redacted] was not signed by the resident and there was no indication that the resident refused to sign, was unable to sign, was unable to participate, or declined to participate.

Plan of Correction

Accept

Resident #1's RASP, dated [redacted] was corrected, please see the attached corrected documents.

All current resident's assessments were audited for missing information and corrected by [redacted]. Starting [redacted] the day shift nurse is responsible for completing or updating RASPs and DMEs. The day shift nurse will leave the documents in a folder for review each night by the night shift nurse. The night shift nurse will audit them for missing or incorrect information and they will be corrected immediately. After audits and corrections are done the assessments will be filed in the resident's medical chart.

Completion Date: 08/16/2021

Update - 08/18/2021

Attachments are reviewed and approved in Step 2.

Please end in a copy of an audit showing work with Step 2.

[redacted], 8-18-21

227g -Support Plan Signatures (continued)

Document Submission

Implemented

Audit document attached 8/19/21 [redacted]

Update - 09/02/2021

Documents reviewed 9-2-21, [redacted]

231b - Medical Evaluation

1. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident’s diagnosis of Alzheimer’s disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 resides in the home's Secured Dementia Care Unit. However Resident #1's DME, dated 12/4/2020, was not completed to indicate the resident's need for a Secured Dementia Care Unit in Section (4).

Plan of Correction

Accept

Resident #1's DME, dated 12/4/2020, was corrected, please see the attached corrected documents.

All current resident's assessments were audited for missing information and corrected by 8/16/2021. Starting 8/16/2021 the day shift nurse is responsible for completing or updating RASPs and DMEs. The day shift nurse will leave the documents in a folder for review each night by the night shift nurse. The night shift nurse will audit them for missing or incorrect information and they will be corrected immediately. After audits and corrections are done the assessments will be filed in the resident's medical chart.

Completion Date: 08/16/2021

Update - 08/18/2021

Attachments are reviewed and approved in Step 2.

Please send in a copy of an audit with the work shown with Step 2.

[redacted] 8-18-21

Document Submission

Implemented

Audit document attached 8/19/21 [redacted]

Update - 09/02/2021

Documents reviewed 9-2-21, [redacted]

**RENEWAL APPLICATION FOR EXISTING CERTIFICATE OF COMPLIANCE**  
**APPLICATION IS MADE HEREWITH TO RENEW THE CERTIFICATE OF COMPLIANCE TO OPERATE**  
**THE FACILITY/AGENCY TO PROVIDE THE SERVICE SPECIFIED**

TYPE OR USE PEN, SIGN AND RETURN

*200 006 005*

**IDENTIFICATION**

|  |   |  |
|--|---|--|
| 1. NAME OF AGENCY/FACILITY<br><b>PHOEBE BERKS VILLAGE</b>  |   | TELEPHONE NUMBER<br><b>(610) 927-8200</b>        |
| FACILITY ADDRESS<br><b>1 READING DRIVE,<br/>WERNERSVILLE PA 19565</b>  | E-MAIL FOR FACILITY (NOT THE WEB SITE URL)<br><b>MBUTCH@PHOEBE.ORG</b>  | 3. COUNTY<br><b>BERKS</b>                        |
| 2. NAME OF LEGAL ENTITY<br><b>PHOEBE BERKS HEALTH CARE CENTER, INC.</b>  |   | TELEPHONE NUMBER<br><b>(610) 927-8200</b>        |
| MAILING ADDRESS (CORRESPONDENCE TO BE DELIVERED TO)<br><b>1 HEILDELBERG DRIVE<br/>WERNERSVILLE PA 19565</b>  | E-MAIL FOR LEGAL ENTITY (NOT THE WEB SITE URL)<br><b>MBUTCH@PHOEBE.ORG</b>  | 4. DATE CERTIFICATE EXPIRES<br><b>07/30/2021</b> |
| 5. NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE<br><b>Michele Butch Personal Care Home Administrator</b>  |   | 5. CERTIFICATE NUMBER<br><b>305360</b>           |
| 7. TYPE OF SERVICE PROVIDED<br><b>PERSONAL CARE HOMES</b>  |   | FEIN OR EGF<br><b>23-2560952</b>                 |
| 8. REQUESTED LICENSED CAPACITY (PERSONAL CARE HOMES AND ASSISTED LIVING FACILITIES)<br><b>91</b>   |   |  |
| 9. TYPE OF OPERATION<br><input type="checkbox"/> PROFIT<br><input checked="" type="checkbox"/> NON-PROFIT  | 10. TYPE OF OWNERSHIP/CONTROL<br><input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> ASSOCIATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> FOREIGN PART <input type="checkbox"/> LLP <input type="checkbox"/> LP<br><input type="checkbox"/> GOVERNMENT <input type="checkbox"/> SCHOOL DISTRICT <input checked="" type="checkbox"/> CORPORATION <input type="checkbox"/> FOREIGN CORP <input type="checkbox"/> LLC <input type="checkbox"/> OTHER |  |
| 11. PRIOR LICENSE STATUS<br>Has the agency/facility (Item 1) or Legal Entity (Item 2), or the Person Responsible (Operator) (Item 6), or the person signing the application ever been denied a Certificate of License, had a Certificate of Compliance or License revoked, or had a Certificate of Compliance or License non-renewed in Pennsylvania or any other state?<br><input type="checkbox"/> YES (IF YES, EXPLAIN ON SEPARATE SHEET) <input checked="" type="checkbox"/> NO  |   |  |
| 12. PLEASE ANSWER THE FOLLOWING (IF YES, EXPLAIN ON SEPARATE SHEET):<br>HAS THE LEGAL ENTITY, OWNER, OR OPERATOR EVER:<br>A. BEEN CONVICTED OF A FELONY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>B. BEEN CONVICTED OF A CRIME INVOLVING CHILD ABUSE, CHILD NEGLECT, MORAL TURPITUDE, OR PHYSICAL VIOLENCE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>C. BEEN NAMED A PERPETRATOR IN AN INDICATED OR FOUNDED REPORT OF CHILD ABUSE IN ACCORDANCE WITH THE CHILD PROTECTIVE SERVICE LAW (11 P.S. 2201-2225) OR THE CARE-DEPENDENT SERVICES ACT (18 PA C.S. 2713) |   |  |
| 13. CURRENT STATUS OF LEGAL ENTITY, OWNER OR OPERATOR<br>IS THE LEGAL ENTITY, OWNER, OR OPERATOR CURRENTLY CHARGED WITH A FELONY OR MISDEMEANOR?<br><input type="checkbox"/> YES (IF YES, EXPLAIN ON SEPARATE SHEET) <input checked="" type="checkbox"/> NO  |   |  |

**RECEIVED**

**MAY 18 2021**

*Human Services Licensing*

**DECLARATION**

Any false information or statement knowingly given in this application is punishable under section 4904 of the PA Crimes Code.

I understand that the Certificate of Compliance will be issued to me on the condition that I will operate the above named facility or agency in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Human Services; Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the PA Human Relations Act of 1955, and I hereby declare that the information given in this application is true to the best of my knowledge.

*Michele Butch*  
 NAME (Type or Print)

*Administrator*  
 TITLE

*Michele Butch*  
 SIGNATURE OF THE LEGAL ENTITY REPRESENTATIVE  
 (When the legal entity is a corporation, the signature must be of a corporate officer.)

*4/20/21*  
 DATE