Department of Human Services
Bureau of Human Service Licensing

November 10, 2021

[redacted], PRESIDENT

RE: AMITY PLACE
139 OLD SWEDE ROAD
DOUGLASSVILLE, PA, 19518
LICENSE/COC#: 22656

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/14/2021, 09/15/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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: *AMITY PLACE* **License #:** *22656* **License Expiration Date:** *10/18/2022*
Address: *139 OLD SWEDE ROAD, DOUGLASSVILLE, PA 19518*
County: *BERKS* **Region:** *NORTHEAST*

Administrator

Name: **Phone:** **Email:**

Legal Entity

Certificate(s) of Occupancy

Type: *I-1* **Date:** *02/19/2009* **Issued By:** *Amity Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *76* **Waking Staff:** *57*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *09/15/2021*

Inspection Dates and Department Representative

09/14/2021 - On-Site:
09/15/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *53*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *53*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *23* **Have Physical Disability:** *0*

Inspections / Reviews

09/14/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/29/2021*

11/4/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/11/2021*

11/10/2021 - Document Submission

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

3c - Post Current License

1. **Requirements**

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Repeat Violation

The home did not have the current license posted.

The home also did not have the license inspection summaries dated 2/17/21 and 8/31/20 posted as required.

This is a repeat violation from 09/24/2019.

Plan of Correction **Accept**

On 9/14/2021, The Regional Director of Care Services (RDCS) conspicuously posted the community's license within the community.

On 9/14/2021, The communities license inspection summaries dated 2/14/21 and 8/31/2020 were noted by the RDCS and remain at the reception desk.

On 10/19/2021, The Executive Director (ED) conspicuously posted within the community, signage identifying the location of previous inspection summaries. (Attachment P1)

On 10/27/2021, The Regional Executive Director (RED) educated the ED on the requirements set within regulation 2600.3.c. (Attachment T1)

The ED or designee will audit, validating the presence of the community's license, inspection summaries, and corresponding signage, weekly x 4 week, bi-weekly x 4 weeks, and monthly x 1. (Attachment A)

Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *10/27/2021*

Document Submission **Implemented**

See Attached

15a - Resident Abuse Report

1. **Requirements**

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On ██/21 resident #1 swung a cane and hit resident #2 in the back of the shoulder. The home did not report this incident to the area agency on aging.

15a - Resident Abuse Report *(continued)*

Plan of Correction **Accept**

Resident #1 or Resident #2 did not suffer an adverse effect related to this finding.
On 10/27/2021, the ED reported the incident to both Area Office of Aging (AAA) and the Departments Personal Care Home Regional Office. (Attachment B3)
On 10/28/2021, the RDCS educated the ED and Care Services Manager (CSM) on the requirements set within regulation 2600.16c. (Attachment T2)
By 11/12/21, The ED or designee will conduct a documentation audit of current resident incidents reports for the preceding 90 days to validate that any identified incidents that require reporting per 2600.16c were reported. For instances or events noted that require reporting per 2600.16c and were not previously reported, the ED or designee will report upon discovery. (Attachment B1)
The ED or designee will review internal resident incident reports weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 to validate that reportable incidents have been reported to the Department. (Attachment B2)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *11/12/2021*

Update - 11/04/2021

Please send/Attach proof of staff training. 11-4-2021 ██

Document Submission **Implemented**

See Attached

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 ██/21 resident #1 swung a cane and hit resident #2 in the back of the shoulder. The home did not report this incident to the department's regional office.

16c - Written Incident Report *(continued)*

Plan of Correction **Accept**

Resident #1 or Resident #2 did not suffer an adverse effect related to this finding.
On 10/27/2021, the ED reported the incident to both Area Office of Aging (AAA) and the Departments Personal Care Home Regional Office. (Attachment B3)
On 10/28/2021, the RDCS educated the ED and Care Services Manager (CSM) on the requirements set within regulation 2600.16c. (Attachment T2)
By 11/12/21, The ED or designee will conduct a documentation audit of current resident incidents reports for the preceding 90 days to validate that any identified incidents that require reporting per 2600.16c were reported. For instances or events noted that require reporting per 2600.16c and were not previously reported, the ED or designee will report upon discovery. (Attachment B1)
The ED or designee will review internal resident incident reports weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 to validate that reportable incidents have been reported to the Department. (Attachment B2)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *11/12/2021*

Update - 11/04/2021

Document Submission **Implemented**

See Attached

25b - Contract Signatures

1. **Requirements**

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The contract dated [redacted] for resident #3 was not signed by the resident. The contract dated [redacted] for resident #4 was not signed by the resident.

25b - Contract Signatures *(continued)*

Plan of Correction **Accept**

Residents #3 and #4 have signed their respective resident-home contracts as of 10/29/2021.
(Attachments P2 and P3)
On 10/27/2021, the RED educated the ED and Community Relations Manager (CRM) on the requirements set within regulation 2600.25.b (Attachment T1)
On 11/01/2021, the ED completed an internal audit of current resident-home contracts to ensure they were signed by the resident. (Attachment C1)
By 11/12/21, Contracts identified as having omitted signatures will be presented accordingly for signing.
The ED and/or designee will audit new resident contracts weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 to validate resident-home contracts were signed by the resident if able. (Attachment C2)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *11/12/2021*

Update - 11/04/2021

Please send/Attach proof of staff training. 11-4-2021 ■

Document Submission **Implemented**

See Attached

63a - First Aid/CPR Training

1. **Requirements**

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 9/5/21 from 10:00pm to 2:00am there were no staff scheduled who had current certified training in First aid and CPR. From 2:00am to 7:00am there was only one staff person in the home with current certified training in First aid and CPR.
On 9/11/21 from 7pm to 10pm there was only 1 staff person with the certified training and from 10pm to 7am there were no staff with the certified training.
The home has a census of 53 residents and requires at least 2 staff persons with certified training in First aid and CPR be present during all shifts.

63a - First Aid/CPR Training *(continued)*

Plan of Correction **Accept**

On 11/01/2021 the ED audited current employee First Aid/CPR training certifications to identify staff in need of recertification. (Attachment D1).
On 9/29/2021 a First Aid/CPR training course was held on-site, certifying 11 additional staff members. (Attachment T4).
On 10/27/2021 the RED educated the ED and CSM on the requirements set within regulation 2600.63a. (Attachment T1)
A second First Aid/CPR training course is scheduled to be held on 11/19/21.
By 11/24/2021, the ED will audit the succeeding 4 weeks of staff schedules, to ensure the presence of two first aid/CPR certified staff members within the community. (Attachment D3)
The ED or designee will audit the employee schedule weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure at least 2 employees are certified in CPR and first aid per shift. (Attachment D2)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *11/24/2021*

Update - 11/04/2021

Please send/Attach proof of staff training. 11-4-2021

Document Submission **Implemented**

See Attached

65f - Training Topics

1. **Requirements**

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff person A did not have training in the required training topic meeting the needs of the residents as described in the preadmission screening form, support plan, and medical evaluation for the 2019 training year.

65f - Training Topics *(continued)*

Plan of Correction **Accept**

On 10/07/2021, the ED trained staff person A on the required training topic of Instruction on meeting the needs of the resident as described in the preadmission screening form assessment tool, medical evaluation and support plan. (Attachment T3)
On 10/27/2021, the RED educated the ED and CSM on the requirements set within regulation 2600.65.f. (Attachment T1)
On 10/28/2021, the ED conducted an audit of current employees, employed during calendar year(s) 2019 and 2020 to validate required training topics, as per 2600.65f were presented. (Attachment E2) Current employees will receive the proper training sessions within 2021.
The ED will audit 3 personnel training records weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure required training topics, as per 2600.65f were presented. (Attachment E1)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *10/28/2021*

Update - 11/04/2021

Please send/Attach proof of staff training. 11-4-2021

Document Submission **Implemented**

See Attached

100a - Exterior - Free of Hazards

1. **Requirements**

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The sidewalk leading from the exit door near room 108 was obstructed by overgrown lavender plants partially covering a section of the walkway.

Plan of Correction **Accept**

On 9/14/2021, the Maintenance Director cleared the sidewalk leading from the exit door near room 108.
On 9/14/2021, the Maintenance Director assessed the community's sidewalks to ensure they are in good repair and free of hazards. No safety concerns, including obstructions were noted.
On 10/27/2021, the RED educated the Maintenance Director, ED, and CSM on the requirements set within regulations 2600.100.a. (Attachment T1)
The ED or designee will assess the community's sidewalks weekly x 4, bi-weekly x 4, and monthly x 1 to ensure they are in good repair and free of hazards. (Attachment F)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *10/27/2021*

Update - 11/04/2021

Please send/Attach invoice and or picture of compliance. 11-4-2021

100a - Exterior - Free of Hazards *(continued)*

Document Submission **Implemented**

See Attached

103e - Left Overs

1. **Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The activity area refrigerator had several foil wrapped soft pretzels stored in the freezer unlabeled and undated.

Plan of Correction **Accept**

On 9/14/2021 the ED removed and disposed of the foil wrapped pretzels.
On 9/14/2021 the ED assessed the refrigerators within the community to ensure no other unlabeled and/or undated food was present and validated compliance.
On 10/27/2021, the RED educated the Food Service Director, ED and Housekeeper on the requirements set within Regulation 2600.103.e. (Attachment T1)
The ED or designee will assess the community's refrigerators weekly x 4, bi-weekly x 4, and monthly x 1 to ensure the food within is properly labeled and dated with a current, unexpired date. (Attachment G)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *10/27/2021*

Document Submission **Implemented**

See Attached

107d - Procedure Emergency Management Agency Submission

1. **Requirements**

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Repeat Violation

The home did not have documentation that the emergency procedures were reviewed and submitted to the local emergency management agency in 2020.
This is a repeat violation from 09/24/2019.

107d - Procedure Emergency Management Agency Submission *(continued)*

Plan of Correction **Accept**

On 10/20/2021, the ED submitted the homes emergency procedures to the local emergency management agency. (Attachment T5)

On 10/20/2021, the ED placed a copy of the dated letter that was submitted to the local emergency management agency within the community's survey binder. (Attachment T5)
On 10/27/2021. The RED educated the ED on the requirements set within regulation 2600.107.d. (Attachment T1)
The community's emergency plan will be reviewed quarterly x 4 by the QI committee to ensure the plan is reviewed, updated, and submitted annually. (Attachment H)

Completion Date: *10/27/2021*

Update - 11/04/2021

Please send/Attach proof of compliance. 11-4-2021 MM

Document Submission **Implemented**

See Attached

141b2 - Medical Evaluation Changes

1. **Requirements**

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #1's documentation of medical evaluation dated [redacted] indicates in section 4 (Special Health or Dietary Needs) that the resident requires secure dementia care. The home does not have a secure dementia unit and the resident currently was no longer in need of secured dementia care.

Plan of Correction **Accept**

On 9/15/2021, Resident #1's Documentation of Medication Evaluation (DME) was corrected by the residents primary care provider to reflect that secure dementia care was not required. (Attachment I2)
On 10/28/2021, the RDCS educated the CSM and ED on the requirements set within Regulation 2600.141.b.2. (Attachment T2)
On 9/14/2021, the CSM reviewed the DME of current residents to validate compliance. No additional resident DME indicated that secure dementia care was required.
The CSM or designee will audit 5 resident DME's weekly x 4 weeks, then bi-weekly x 2 weeks, then monthly x 1 to validate compliance. (Attachment I1)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *10/28/2021*

Document Submission **Implemented**

See Attached

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:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

The Medication Record for resident #5 had the PRN prescription medications [redacted] listed on it. The medications were not in the medication cart and it was determined that there were no current orders for those medications. The medications were listed on the Medication record in error.

Plan of Correction **Accept**

On 9/14/2021, the CSM discontinued the medications of [redacted] from Resident # 5's medication administration record (MAR). (Attachment M)
On 10/28/2021, the RDCS educated the CSM and ED on the requirements set within Regulation 2600.187.a. (Attachment T2)
By 11/12/21, the CSM will audit current resident MARs validating the presence of only current and active medication orders. (Attachment J1)
The CSM or designee will audit 5 resident MARs weekly x 4, bi-weekly x 4, and monthly x 1 to ensure that they reflect only current and active medication orders. (Attachment J2)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *11/12/2021*

Document Submission **Implemented**

See Attached

225a - Assessment 15 Days

1. **Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

225a - Assessment 15 Days *(continued)*

Description of Violation

Resident #4 moved into the home on [redacted]. The resident's support plan was completed on [redacted]. The home did not complete an initial assessment of the resident's needs within 15 days after the resident's admission date of [redacted]

Plan of Correction **Accept**

On [redacted], the support plan for Resident #4 was updated to reflect the compliant finalization date of [redacted], which is the date the support plan was presented and signed by resident #4. (Attachment N)
On [redacted] the RDCS educated the CSM on the requirements set within Regulation 2600.225.a. (Attachment T2)
By 11/12/21, the CSM will audit current resident support plans to validate their completion within the first 15 days of admission. Support plans identified to have omitted initial assessments will be completed upon discovery. (Attachment K1))
The CSM or designee will audit 5 resident support plans weekly x 4, bi-weekly x 4, and monthly x 1 to validate they are finalized within the first 15 days of admission. (Attachment K2)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *11/12/2021*

Document Submission **Implemented**

See Attached

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 support plan dated [redacted] for resident #1 was completed for the reason "significant change". The significant change was not listed on the support plan. The support plan also did not list the hospice caregiver services the resident is receiving.

227d - Support Plan Medical/Dental *(continued)*

Plan of Correction **Accept**

On 9/15/2021, Resident #1's support plan was updated by the CSM to reflect resident's significant change including hospice services being provided. (Attachment O)
On 10/28/2021, the RDCS educated the CSM on the requirements set within Regulation 2600.227.d. (Attachment T2)
By 11/12/2021, the CSM will audit current resident support plans to ensure a resident with an identified significant change has a corresponding support plan updated to identify the significant change. Resident support plans identified to be out of compliance will be updated accordingly. (Attachment L1)
The CSM or designee will audit the support plans of residents with a "significant change" status weekly x 4, bi-weekly x 4, and monthly x 1 to validate the significant change is identified and the correct care services are included within the plan. (Attachment L2)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: *11/12/2021*

Document Submission **Implemented**

See Attached