pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: August 4, 2022

[redacted]
Phoebe Berks Health Care Center, Inc.
[redacted]

RE: Phoebe Berks Village
1 Reading Drive
Wernersville, Pennsylvania 19565
License #: 205360

Dear [redacted]:

As the result of your home's recent request to adjust the use of the physical space, the Department has granted an approval for a revised license issued under the authority of 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The approved capacity revision request is an increase in the Secured Dementia Care Unit from 25 to 37. Total capacity is 103. The expiration date of the license remains unchanged.

Any future requests for changes in capacity should be forwarded to the Department for review and consideration in accordance with the applicable regulations. The revised license is enclosed.

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
License

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

Facility Information

Name: *PHOEBE BERKS VILLAGE* **License #**: *20536* **License Expiration**: *07/30/2023*

Address: *1 READING DRIVE, WERNERSVILLE, PA 19565*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: *6109278200* **Email**: [redacted]

Legal Entity

Name: *PHOEBE BERKS HEALTH CARE CENTER, INC.*

Address: [redacted]

Phone: *6109278200* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/04/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *107* **Waking Staff**: *80*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *07/14/2022*

Inspection Dates and Department Representative

06/28/2022 - On-Site: [redacted]

06/29/2022 - On-Site: [redacted]

07/14/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *91* **Residents Served**: *82*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *0* **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**: *82*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *25* **Have Physical Disability**: *0*

Inspections / Reviews

06/28/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/28/2022*

08/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/08/2022*

08/02/2022 - Document Submission

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

65b - Rights/Abuse 40 Hours

1. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff A, [redacted], first day of work was [redacted]21. Staff A completed 40 hours of work on [redacted]/21. Staff A did not complete orientation on Resident rights, emergency medical plan, mandatory reporting of abuse, or reporting incidents or conditions within the first 40 hours worked.

Plan of Correction ***Accept***

Staff Development created a training guide and a checklist that includes the first 8 hour and the first 40 hour training competencies. The guide will be used for training [redacted] staff the first day they pick up in our facility. The [redacted] staff person who did not have the 40 hour training did complete the training and we reviewed all other [redacted] staff to ensure they all had the proper training. Attached is the training checklist for the [redacted] person who did not have the training. A read and sign was presented to LPNs to ensure that they are aware of the new process and that they are responsible for providing the training to [redacted] staff on their first shift. LPNs will return checklists to the scheduler who will keep the completed checklist to ensure compliance.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of staff training.

Document Submission ***Implemented***

Staff Development created a training guide and a checklist that includes the first 8 hour and the first 40 hour training competencies. The guide will be used for training [redacted] staff the first day they pick up in our facility. The [redacted] staff person who did not have the 40 hour training did complete the training and we reviewed all other [redacted] staff to ensure they all had the proper training. Attached is the training checklist for the [redacted] person who did not have the training. A read and sign was presented to LPNs to ensure that they are aware of the new process and that they are responsible for providing the training to [redacted] staff on their first shift. LPNs will return checklists to the scheduler who will keep the completed checklist to ensure compliance.

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #2 utilizes an enabler on the bed. The enabler has a space larger than 4.75 inches and on 7/14/22 at 12:30pm, the enabler was not covered.

Plan of Correction ***Accept***

All resident rooms were audited for bed enablers and any not covered were covered, including resident #2. Resident #2 did not have a bed enabler, I think this was a typo and but I think the inspector meant [redacted] as [redacted] had inspected room[redacted] but not the room that resident #2 occupies. Staff workflows and residents orders have been added to include changing bed enabler cover on shower days. Administrator has added this to the monthly audit list in the Village Commons, it was already on the monthly audit list for the Village Gardens memory support audits. Administrator will also audit rooms monthly to ensure compliance.

Completion Date: *07/26/2022*

81b - Resident Personal Equipment *(continued)*

Update: *08/01/2022*

Please send proof of compliance (picture).
Resident #8 - [redacted] for reference.

Document Submission ***Implemented***

All resident rooms were audited for bed enablers and any not covered were covered, including resident #2. Resident #2 did not have a bed enabler, I think this was a typo and but I think the inspector meant [redacted] as [redacted] had inspected room [redacted] but not the room that resident #2 occupies. Staff workflows and residents orders have been added to include changing bed enabler cover on shower days. Administrator has added this to the monthly audit list in the Village Commons, it was already on the monthly audit list for the Village Gardens memory support audits. Administrator will also audit rooms monthly to ensure compliance.

101j7 - Lighting/Operable Lamp

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

Description of Violation

Residents in rooms 70, 81, 204, and 307 did not have a lamp within reach of each resident's bed.

Plan of Correction ***Accept***

All resident rooms were audited for bed side lights. Staff workflows and resident's orders have been added to include checking on shower days that the bedside light is within reach from resident bed and that it is in working condition. Administrator has added this to the monthly audit list in the Village Commons and Village Gardens. Administrator will also audit rooms monthly to ensure compliance.
Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of compliance (picture).

Document Submission ***Implemented***

All resident rooms were audited for bed side lights. Staff workflows and resident's orders have been added to include checking on shower days that the bedside light is within reach from resident bed and that it is in working condition. Administrator has added this to the monthly audit list in the Village Commons and Village Gardens. Administrator will also audit rooms monthly to ensure compliance.

102f - Towel/Washcloth/Soap

1. Requirements

2600.
102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

Resident # 9 and #10 share room [redacted]. Located in the bathroom was 1 hand towel and 2 separate wash clothes. The hand towel is a shared hand towel. The wash clothes are not labeled with the resident's names.

Plan of Correction ***Accept***

The towel bars in each room of a shared accommodations have been labeled so that each resident has their own hand towel and wash cloth. A read and sign was provided to all staff to educate them on this regulation and the expectation of providing a separate washcloth and hand towel to each resident in a shared room. Administrator

102f - Towel/Washcloth/Soap (continued)

will also audit rooms monthly to ensure compliance.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of compliance (picture).
Please send proof of staff training.

Document Submission ***Implemented***

The towel bars in each room of a shared accommodations have been labeled so that each resident has their own hand towel and wash cloth. A read and sign was provided to all staff to educate them on this regulation and the expectation of providing a separate washcloth and hand towel to each resident in a shared room. Administrator will also audit rooms monthly to ensure compliance.

103i - Outdated Food

1. Requirements

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

Description of Violation

Located in the ground floor kitchenette was a bag of chopped salad that had expired on 7/4/22. Located in the 1st floor kitchenette was a container of diced peaches. The container had a residents name on it but did not indicate the date this item was placed in the refrigerator or the expiration date.

Plan of Correction ***Accept***

All common refrigerators in the Village Commons have been provided labels so that residents and activity staff can label food items with their name the date the item was placed on the refrigerator. This was discussed on 7/19/22 in resident council so that residents are aware of the regulation and that they should be labeling all food they place in the refrigerators. Weekly cleaning out of refrigerators has been added to the nightshift workflows to ensure expired food is thrown out. A read and sign has been provided to all staff to education them on the regulation so they know the expectation. Administrator has added this to the monthly audit list to ensure compliance.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Document Submission ***Implemented***

All common refrigerators in the Village Commons have been provided labels so that residents and activity staff can label food items with their name the date the item was placed on the refrigerator. This was discussed on 7/19/22 in resident council so that residents are aware of the regulation and that they should be labeling all food they place in the refrigerators. Weekly cleaning out of refrigerators has been added to the nightshift workflows to ensure expired food is thrown out. A read and sign has been provided to all staff to education them on the regulation so they know the expectation. Administrator has added this to the monthly audit list to ensure compliance.

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

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff

185a - Implement Storage Procedures (continued)

incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident # 7 – At 11:26am on [redacted]/22 the reading on the glucometer was 190 but was incorrectly transcribed as 192 and at 5:43pm the reading on the glucometer was 261 but was incorrectly transcribed as 231.

Plan of Correction ***Accept***

LPNs and Med Techs were provided a read and sign training about the importance of recording glucometer meter reading correctly in the MAR. This was an error we were aware of and we had previously spoken to and retrained the 2 LPNs that made the errors. These were the first errors found for both nurses, our policy is to retrain the staff member who made a first mistake. Glucometer audits are done weekly and education is provided from Staff Development to anyone who makes a mistake.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of staff training.

Document Submission ***Implemented***

LPNs and Med Techs were provided a read and sign training about the importance of recording glucometer meter reading correctly in the MAR. This was an error we were aware of and we had previously spoken to and retrained the 2 LPNs that made the errors. These were the first errors found for both nurses, our policy is to retrain the staff member who made a first mistake. Glucometer audits are done weekly and education is provided from Staff Development to anyone who makes a mistake.

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On [redacted]/22, an assessment was completed on Resident #2. The assessment was completed due to a significant change. Resident #2 returned to the home on [redacted]/22 after a rehab stay from [redacted]/22 to [redacted]/22. The significant change was not completed within 5 days of residents return.

Plan of Correction ***Accept***

LPNs were provided a read and sign to educate them on the RASP process and the timing of RASPs and specifically that a significant change RASP needs to be implemented within 5 days. Going forward, the RASPs will be audited when residents return from the HCC with significant changes. Administrator will also audit rooms monthly to ensure compliance.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of staff training.

Document Submission ***Implemented***

LPNs were provided a read and sign to educate them on the RASP process and the timing of RASPs and specifically that a significant change RASP needs to be implemented within 5 days. Going forward, the RASPs will be audited when residents return from the HCC with significant changes. Administrator will also audit rooms monthly to ensure compliance.

227c - Support Plan Revision

1. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

On [redacted]/22, a support plan was completed on Resident #2. The support plan was completed due to a significant change. Resident #2 returned to the home on [redacted]/22 after a rehab stay from [redacted]/22 to [redacted]/22. Resident #2's care needs had changed and were not addressed in the support plan until [redacted] days after Resident #2 returned to the home.

Plan of Correction ***Accept***

LPNs were provided a read and sign to educate them on the RASP process and the timing of RASPs and specifically that a significant change RASP needs to be implemented within 5 days. Going forward, the RASPs will be audited when residents return from the HCC with significant changes. Administrator will also audit rooms monthly to ensure compliance.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of staff training.

Document Submission ***Implemented***

LPNs were provided a read and sign to educate them on the RASP process and the timing of RASPs and specifically that a significant change RASP needs to be implemented within 5 days. Going forward, the RASPs will be audited when residents return from the HCC with significant changes. Administrator will also audit rooms monthly to ensure compliance.

231c - Preadmission Screening

1. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #3 did not have a cognitive prescreen completed prior to admission to the Secured Dementia Unit.

Plan of Correction ***Accept***

Administrator and LPNs were provided a read and sign to educate them on the cognitive prescreen and filing out the section determining the need for a secured dementia unit. Prescreens are audited and the education was also provided to the LPNs auditing them. All other prescreens were reviewed to ensure compliance with this regulation the prescreen for this resident was corrected. Administrator will add this to the audit monthly audit list to for the secured dementia unit.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of compliance - Resident 3's cognitive prescreen.

Document Submission ***Implemented***

Administrator and LPNs were provided a read and sign to educate them on the cognitive prescreen and filing out the section determining the need for a secured dementia unit. Prescreens are audited and the education was also provided to the LPNs auditing them. All other prescreens were reviewed to ensure compliance with this regulation the prescreen for this resident was corrected. Administrator will add this to the audit monthly audit list to for the

231c - Preadmission Screening (continued)

secured dementia unit.

231e - No Objection Statement

1. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secured Dementia Unit on [redacted]22. The home did not have documentation that Resident #4 and their designee did not object to the resident's transfer to the secure dementia care unit.

Plan of Correction ***Accept***

Resident family did not complete the electronic document signing process, this has since been corrected. All other resident documents were audited to ensure that all have been signed by family. A read and sign for the admissions department was also provide to educate them on the this regulation and to ensure compliance moving forward. Going forward the administrative assistance for sales will be following up with family to ensure that all documents have been signed by the day of move in. Administrator will add this to the audit monthly audit list for all new residents.

Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of compliance - Resident 4's documentation - SDCU.

Document Submission ***Implemented***

Resident family did not complete the electronic document signing process, this has since been corrected. All other resident documents were audited to ensure that all have been signed by family. A read and sign for the admissions department was also provide to educate them on the this regulation and to ensure compliance moving forward. Going forward the administrative assistance for sales will be following up with family to ensure that all documents have been signed by the day of move in. Administrator will add this to the audit monthly audit list for all new residents.

252 - Record Content

1. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident #2 and Resident #5's resident record does not indicate the residents race. Resident #6's record does not contain religion or race.

Plan of Correction ***Accept***

Resident 2, 5 and 6 information was updated and a complete audit of all resident information was done to ensure that we are in compliance with this regulation. A read and sign for the admissions department was also provide to educate them on the this regulation and to ensure compliance as they are responsible for this information. We are in the process of updating these fields so that the are required fields and will have to be set up at the time of admissions, this should ensure compliance. In the meantime, the administrator will add this to the monthly audit list for all new residents.

Completion Date: *07/26/2022*

252 - Record Content *(continued)*

Update: *08/01/2022*

Please send proof of compliance for Resident's 2, 5 and 6.

Document Submission ***Implemented***

Resident 2, 5 and 6 information was updated and a complete audit of all resident information was done to ensure that we are in compliance with this regulation. A read and sign for the admissions department was also provide to educate them on the this regulation and to ensure compliance as they are responsible for this information. We are in the process of updating these fields so that the are required fields and will have to be set up at the time of admissions, this should ensure compliance. In the meantime, the administrator will add this to the monthly audit list for all new residents.

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 #3 was admitted to Secured Dementia Unit (SDCU) on [redacted]/22. Resident #3's DME, dated [redacted]/22, did not indicate a SDCU was authorized by the physician.
repeat - 7/13/21

Plan of Correction ***Accept***

Administrator and LPNs were provided a read and sign to educate them on the DME and filing out the section determining the need for a secured dementia unit by the physician for all residents coming to a secured dementia unit. DMEs are audited and the education was also provided to the LPNs auditing them. All other DMEs were reviewed to ensure compliance with this regulation the DME for this resident was corrected by PCP. Administrator will add this to the audit monthly audit list to for the secured dementia unit.
Completion Date: *07/26/2022*

Update: *08/01/2022*

Please send proof of staff training.

Document Submission ***Implemented***

Administrator and LPNs were provided a read and sign to educate them on the DME and filing out the section determining the need for a secured dementia unit by the physician for all residents coming to a secured dementia unit. DMEs are audited and the education was also provided to the LPNs auditing them. All other DMEs were reviewed to ensure compliance with this regulation the DME for this resident was corrected by PCP. Administrator will add this to the audit monthly audit list to for the secured dementia unit.