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

February 28, 2023

[redacted], ADMINISTRATOR
READING AID II OPCO LLC
[redacted]

RE: MAIDENCREEK PLACE
105 DRIES ROAD
READING, PA, 19605
LICENSE/COC#: 22658

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/06/2022, 07/07/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MAIDENCREEK PLACE* **License #**: *22658* **License Expiration**: *05/15/2023*

Address: *105 DRIES ROAD, READING, PA 19605*

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

Administrator

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

Legal Entity

Name: *READING AID II OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *10/01/2004* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *11* **Total Daily Staff**: *83* **Waking Staff**: *62*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/07/2022*

Inspection Dates and Department Representative

07/06/2022 On Site: [redacted]

07/07/2022 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *61*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *61*

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

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

07/06/2022 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *08/01/2022*

Inspections / Reviews *(continued)*

12/04/2022 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/04/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *12/12/2022*

01/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/04/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/03/2023*

02/28/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/04/2023*

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

26b - Quality Management Plan Content

1. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
2. Complaint procedures.
3. Staff person training.

Description of Violation

The quality management review conducted on July 2021 did not address staff training and complaint procedures.

Plan of Correction ***Accept [redacted] - 01/27/2023)***

Submission of this response andPlace of Correction is NOT a legal admission that deficiency exists or, that this State of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

• On 10/13/2022, the Regional Care Specialist (RCS) educated the Executive Director (ED), and the Care Services Manager (CSM), as to the requirements set within regulation 2600.26b (In-service – A1)

• On 7/11/2022, The ED updated the Quality Management Plan minutes to include complaint procedures and monthly staff training.

• Beginning 8/11/2022, the ED will audit the current month's Quality Management Plan monthly x 3 months to ensure the meetings minutes include complaint procedures and monthly staff training. (Audit tool – A2)

• 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

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented [redacted] - 02/28/2023)

63a - First Aid/CPR Training

2. 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

The home currently serves 61 residents and is required to have two staff members certified in First Aid and CPR present in the home at all times. On [redacted] only one staff member was certified in FA and CPR from [redacted]. On [redacted] only one staff member was certified in CPR from [redacted].

Plan of Correction ***Accept ([redacted] - 01/27/2023)***

On 7/11/2022 the ED audited the succeeding four weeks of staff schedules, to ensure the adequate number of first aid/CPR certified staff members within the community on each shift to meet the requirements set within regulation 2600.63a. (Audit tool - B1)

• On 7/11/2022 the ED audited current employee First Aid/CPR training certifications to identify staff in need of recertification. (Audit tool - B2)

63a First Aid/CPR Training (continued)

• On 10/22/2022 a First Aid/CPR training course was held on site, certifying 24 additional staff members. (Attachment B3)

• On 10/13/2022 the RCS educated the ED and CSM on the requirements set within regulation 2600.63a. (In service B4)

• The ED or designee will audit the staffing schedule weekly x 4 weeks, then bi weekly x 4 weeks, and then monthly x 1 month to ensure an adequate number of CPR and first aid certified staff persons are scheduled each shift to meet the requirements set within regulation 2600.63a. (Audit tool B5)

• 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.

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented [redacted] - 02/28/2023)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Agency staff member A hired [redacted] did not receive training in the first day general fire safety orientation.

Plan of Correction ***Accept ([redacted] - 01/27/2023)***

· As of [redacted], Staff person A, agency CNA, was no longer employed by the home.

· On 7/11/2022, the ED implemented an orientation plan for ancillary staff persons, substitute personnel and volunteers that includes general fire safety and emergency preparedness that includes the following: 1) Evacuation Procedures, 2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation, 3) the designated meeting place outside of the building or within the fire safe area in the event of an actual fire. 4) Smoking safety procedures, the home's smoking policy and location of smoking areas. 5) Location and use of the fire extinguishers. 6) Smoke detectors and fire alarms. 7) Telephone use and notification of emergency services. (Attachment C1)

· On 10/13/2022, the RCS educated the ED, CSM, and the Administrative Assistant (AA) on the requirements set within regulation 2600.65(a). (In service C2)

· On 7/12 7/13,2022 the ED audited personnel records of current direct care staff persons, including ancillary staff person's, substitute personnel and volunteers to ensure fire safety and emergency orientation has been completed.

65a FS Orientation 1st Day (continued)

For instances identified where orientation was not completed, the ED completed the orientation. (Audit tool C3)
· The ED and/or designee will audit personnel records of newly hired direct care staff, including ancillary staff persons, substitute personnel, and volunteers weekly x 4 weeks, then bi weekly x 4weeks then monthly x1 to ensure compliance with regulation 2600.65(a).. (Audit tool C4)
· Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented [redacted] - 02/28/2023)

65b - Rights/Abuse 40 Hours

4. 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:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Agency staff member A hired [redacted] did not receive training in resident rights, The Older Adult Protective Services Act, emergency medical plan and reporting of reportable incidents and conditions within the first 40 hours worked.

Plan of Correction ***Accept ([redacted] - 01/27/2023)***

· As of [redacted], Staff member A, agency CNA, was no longer employed by the home.
· On 7/11/2022, the ED implemented an orientation plan for direct care staff persons, ancillary staff persons, substitute personnel and volunteers that includes, 1) Resident rights, 2) Emergency medical plan, 3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. 10225.101 10225.5102). (Attachment D1)
· On 10/13/2022, the RCS educated the ED, CSM, and the AA on the requirements set within regulation 2600.65(b). (In service D2)
· On 7 12 7/13, 2022, the ED audited the personnel records of current direct care staff persons, including ancillary staff person's, substitute personnel and volunteers to ensure Resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions orientation has been completed. For instances identified where orientation was not completed, the ED completed the orientation. (Audit tool D3)
· The ED and/or designee will audit personnel records of newly hired direct care staff including ancillary staff persons, substitute personnel, and volunteers weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x1 to ensure compliance with regulation 2600.65(b). (Audit tool D4)
· Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *12/07/2022*

65b - Rights/Abuse 40 Hours *(continued)*

Implemented [redacted] - 02/28/2023)

132a - Monthly Fire Drill

5. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home did not conduct a fire drill in May and June 2022.

Plan of Correction ***Accept ([redacted] - 01/27/2023)***

• On 7/28/2022 (2nd shift), 8/18/2022 (3rd sift), 9/12/2022 (1st shift), 10/26/2022 (2nd shift) the ED conducted an unannounced fire drill on each shift. (Drill Log– E1)
• On 10/13/2022, The Regional Executive Director (RED) educated the ED and Maintenance Technician, as to the requirements set within regulation 2600.132.a. (In-service- E2)
• Beginning 7/11/2022, the ED will audit the Fire Drill Log monthly x 3 months to validate an unannounced drill occurs at least once a month (Audit tool – E3)
• Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented ([redacted] - 02/28/2023)

183a - Original Containers and Injections

6. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

It has been determined through staff interviews that if a resident leaves the facility for the day and the medications are packaged in blister packs the staff will pop the pills into a plastic baggie and label the bag. The home is removing the medication from its original container.

Plan of Correction ***Accept [redacted] - 01/27/2023)***

• On 7/8/2022 the CSM audited resident Leave of Absences occurring over the preceding 90 days, validating that residents did not have a negative outcome related to this finding. (Audit tool)
• On 7/8/2022 the ED educated the CSM and Medication Technicians on the requirements set within DHS regula tion 2600.183.a and Enlivant Policy 02-2.13 Release of Medication (In-service – F1)
• Beginning 10/3/2022 the CSM or designee will audit the home resident Leave of Absence (LOA) LOA log and corresponding medication disposition forms weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate residents medications are kept in their original labeled containers while on LOA. (Audit tool – F2)
• 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

183a - Original Containers and Injections (continued)

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented (- 02/28/2023)

184a - Resident's Meds Labeled

7. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 has an order for Hold for systolic blood pressure less than 110. The label to the medication doesn't indicate the blood pressure parameter.

Resident #2 has an order for . The bottle to the medication notes , the label to the medication is incorrect.

Resident #2 has a PRN order for . The label to the medication notes it doesn't include the dosage and instructions for administration.

Resident #2 has a PRN order for) 1 hour before dental procedure. The label to the medication notes , it doesn't include the dosage and instructions for administration.

Plan of Correction ***Accept - 01/27/2023)***

Violation being withdrawn by the department as per
2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented - 02/28/2023)

185a - Implement Storage Procedures

8. 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 #1's PRN was not available.

Resident #3's PRN were not available.

Resident #4's PRN were not available.

185a - Implement Storage Procedures (continued)

Resident #2's PRN [redacted] was not available.

Resident #5's PRN [redacted] was not available.

Plan of Correction ***Accept [redacted] - 01/27/2023)***

On 7/6/2022 the CSM ordered Resident #1's [redacted], Resident #2's [redacted], Resident #3's [redacted] Resident #4's PRN [redacted], and Resident #5's PRN [redacted] from the pharmacy. These medications were delivered to the community on 7/9/2022.
On 7/7/2022 the ED educated the CSM and Medication Technicians on the requirements set within DHS regulation 2600.185.a. (In-service – H1)
On 7/11-7/12-2022 the CSM audited the current residents PRN medications to ensure they were on-hand. No additional missing medications were noted. (In-service – H2)
Beginning 10/13/2022 the CSM or designee will audit the availability of 3 current residents PRN medications weekly x 4 weeks, then bi-weekly x 4 weeks, the monthly x 1 to validate PRN medications are on-hand. (Audit tool – H3)
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

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented ([redacted] - 02/28/2023)

186c - Change in Medications

9. Requirements

2600.
186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

Description of Violation

A verbal order was given to discontinue Resident #5's [redacted] by mouth daily hold 1 tablet and give 2 tablets for weight less than 198 on [redacted] The home did not have a written order from the prescriber within 48 hours of receiving the verbal order.

Plan of Correction ***Accept ([redacted] - 01/27/2023)***

• On 7/7/2022 resident #5's physician provided a written order to discontinue resident [redacted] as of [redacted].
• On 7/8/2022 the ED educated the CSM, Medication Technicians, and Resident #5's prescribing physician on the requirements set within regulation 2600.186.c (In-service - I1)
• On 7/11/2022 the CSM audited the current resident MARs to validate orders initiated or discontinued for the current month had a corresponding prescriber written order or telephone order received and transcribed by a licensed nurse (Audit tool – I2)
• Beginning 10/13/2022 the CSM or designee will audit the current months MAR weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to validate orders initiated or discontinued had a corresponding prescriber written or telephone order received in the residents record. and transcribed by a licensed nurse. (Audit tool – I3)
• 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

186c - Change in Medications (continued)

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented (- 02/28/2023)

187a - Medication Record

10. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #4's [redacted] did not have a diagnosis/purpose listed on the MAR.

Resident #2 has an order for [redacted]. The MAR notes [redacted] daily, the MAR is incorrect.

Plan of Correction ***Accept (- 01/27/2023)***

• On 7/7/2022 the CSM transcribed the diagnosis/purpose of Resident #4's medications: [redacted] #4, [redacted] and [redacted] to the MAR.

• On 7/8/2022 the ED educated the CSM and medication technicians on the requirements set within DHS regulation 2600.187.a. (In-service – J1)

• On 7/8/2022 the CSM audited the current month's MARs for omitted medication purposes or associated diagnoses. Upon identifying an omission, the CSM updated the MAR accordingly. (Audit tool – J32)

• Beginning 10/13/2022 the CSM or designee will audit the MARs belonging to 3 current residents weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 for omitted medication purposes or associated diagnoses. (Audit tool – J34)

• 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

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented (- 02/28/2023)

187c - Refusal of Medication

11. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

187c - Refusal of Medication *(continued)*

Description of Violation

Resident #1 refused [redacted] on [redacted] at [redacted]pm, the prescriber was not notified regarding the refusal.

Plan of Correction ***Accept [redacted] - 01/27/2023)***

• On 7/8/2022 the CSM notified Resident #1's prescriber of resident's [redacted] refusal.
• On 7/8/2022 the ED educated the CSM and medication technicians on the requirements set within regulation 187c (In-service – L1)
• On 10/13/2022 the CSM audited the current month's MARs for medication refusals and corresponding documentation to reflect prescriber notification. No additional instances were noted. (Audit tool- L2)
• Beginning 10/13/2022 the CSM or designee will audit 3 residents MARs weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 for medication refusals and corresponding documentation to reflect prescriber notification. (Audit tool- L3)
• 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

Licensee's Proposed Overall Completion Date: *12/07/2022*

Implemented ([redacted] - 02/28/2023)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident #1's [redacted] was witheld on [redacted] the home does not have a hold order to do so.

Resident #5 has a PRN order for [redacted] 1 tablet daily for weight greater than [redacted], the home is not taking the residents weights.

Plan of Correction ***Accept ([redacted] - 01/27/2023)***

• On 7/8/2022 Resident #1's physician provided the home with an order to hold resident #1's [redacted] for loose stools.
• On 7/8/2022 the ED educated the CSM on the requirements set within DHS regulation 2600.187d. (In-service- M1)
• On 7/7/2022 Resident #5's PRN order to for [redacted] 1 tablet daily for weight greater than 198lbs was discontinued by the provider.
• On 7/8/2022 the CSM educated current staff on the requirements set within DHS regulation 2600.187d (In-service- M2)
• On 10/13/2022 the CSM audited current resident Medication Administration Records (MARs) to identify additional instances of medications being held without an order to hold. No additional instances were noted. (Audit tool – M3)
• On 7/11/2022 the CSM auditing current resident PRN orders to identify if weights were required prior to administration. No additional instances were noted. (Audit tool – M4)
• Beginning 10/13/2022 the CSM or designee will audit 3 resident MARS weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to identify instances of medication administrations being held without an order to hold. (Audit tool –M5)
• Beginning 10/13/2022 the CSM or designee will audit 3 residents physician orders weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to identify if weights are required prior to a PRN medication and validate weights are

187d Follow Prescriber's Orders (continued)

being recorded (Audit tool M6)

• 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

Licensee's Proposed Overall Completion Date: 12/07/2022

Implemented ([redacted] - 02/28/2023)