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

March 7, 2023

[redacted]
REBECCA S PERSONAL CARE HOME INC
118 MASTERS AVENUE
EVERETT, PA, 15537

RE: REBECCA'S AT EVERETT
118 MASTERS AVENUE
EVERETT, PA, 15537
LICENSE/COC#: 3240

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/20/2022 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: *REBECCA'S AT EVERETT* **Licen e #**: *32407* **Licen e Expiration**: *06/03/2023*

Address: *118 MASTERS AVENUE, EVERETT, PA 15537*

County: *BEDFORD* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *REBECCA S PERSONAL CARE HOME INC*

Address: *118 MASTERS AVENUE, EVERETT, PA, 15537*

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *12/09/1996* **I ued By**: *D L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *29* **Waking Staff**: *22*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/20/2022*

Inspection Dates and Department Representative

12/20/2022 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *37* **Residents Served**: *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *26*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *2* **Have Physical Disability**: *1*

Inspections / Reviews

12/20/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/13/2023*

01/23/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/16/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/30/2023*

Inspections / Reviews *(continued)*

01/31/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/10/2023*

02/14/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/21/2023*

03/07/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2023*

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

Residents #4, #5 and #6 expired in the home during 2022. The home did not report these incidents to the Department.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

Effective immediately, the administrator and manager will review all incidents and email them to the department at the time of the incident. The owner of the care home will also be notified immediately of all reportable incidents. The administrator has begun to audit all incidents on 01/12/2023. All staff are being retrained on reportable ncidents and the home policy on reporting, and deadlines. The administrator will be training will be done on 01/29/2022 at 2pm. The administrator will address the retraining of reportable incidents at the monthly quality management meeting on 02/03/2023 at 2 pm. The administrator assistant will audit incident reports monthly to ensure reportable incidents are being reported properly.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented ([redacted] - 03/07/2023)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 12/20/22 at approximately 9:55 AM, the battery-operated carbon monoxide alarm in the kitchen did not work when the test button was pressed. There was no date to determine when the battery was last changed. Per the Care Facility Carbon Monoxide Alarm Standards Act, the battery is to be changed at least once annually.

Plan of Correction ***Directed [redacted] - 01/31/2023)***

The battery was changed and the device tested. The device is operating normally. Dates were placed on the device as to when the batteries were changed. The batteries for the smoke detectors and carbonized alarms were changed and dated by the administrator assistant on 01/04/2023. The administrator has created a checklist to check these and assign them to be checked monthly by our maintenance on 01/04/2023. Before our monthly meeting on the first of every Friday, the administrative assistant will audit the smoke alarms to ensure that everything is up to date and working.

Directed -
Beginning February 2023, the administrative assistant will begin the monthly audit of the smoke alarms to ensure that all are up to date and working.

Directed Completion Date: *02/03/2023*

Implemented [redacted] - 02/14/2023)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct Care Staff Person A, hired on [redacted]19, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept[redacted] - 01/31/2023)***

Staff person A was removed from the schedule on [redacted]2022 as Direct Care staff. And has been placed on a cleaning job until diploma is presented. The administrator and the Administrator assistant have created a new check ist for hiring requirements to ensure that the staff person has all their documents to perform the job. This was completed on 01/23/2022. The administrative assistant will audit staff files on the first Friday of every month before our monthly staff meetings. Attached is the new check list we are using. Our next meeting is on February 3rd, 2023, at 2 pm.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented[redacted] - 03/07/2023)

63a - First Aid/CPR Training

4. 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 [redacted]22 and [redacted]/22, the home had staff persons working, who were trained in CPR, but no staff persons were trained in first aid.
On [redacted]/22 from 2 10 pm, Staff Persons D and G were the only staff persons in the home, and neither are currently certified in first aid and CPR.
On [redacted]/22 from 2 10 pm, Staff Persons D and H were the only staff persons in the home, and neither are currently certified in first aid and CPR.

Plan of Correction ***Accept[redacted] - 01/31/2023)***

CPR and first aid training was completed in the past year but due to the instructor passing away Rebecca's staff did not receive the cards showing that this class was completed. All of Rebecca's staff are enrolled in a CPR and First aid class that will be completed on 01/29/2023 at 3 pm. A Checklist has been made for the administrator or administrator assistant to audit each staff files every staff meeting on the first Friday of every month. The next staff meeting is Feb 3rd at 2 pm is when we will begin monthly reviews. Attached is a checklist we are using. The administrator will review the monthly schedule at this meeting to ensure a CPR/first Aid certified staff member is on shift at all times. During this meeting the administrator will address all of the training that needs to be done in the quality management portion.

63a - First Aid/CPR Training (continued)

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented [redacted] - 02/14/2023)

81b - Resident Personal Equipment

5. 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

On 12/20/22 at 10:05 am, the shower chair in the shower room had an approximate 3 inch by 3 inch piece of the cushion missing.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

The Shower chair was removed by the administrator on 12/20/2023. A new chair was put in the shower on 12/21/2023. An audit will be completed monthly on the first Friday of every month to ensure everything is in good standing order. A checklist was created to ensure that everything is being checked and is in good standing order. This will begin on 02/03/2023.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented [redacted] - 03/07/2023)

101j4 - Bedroom Storage Area

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

Description of Violation

Resident #7 in Room [redacted] has a chest of drawers, but does not have a closet or wardrobe space with clothing racks or shelves,

Plan of Correction ***Directed [redacted] - 01/31/2023)***

A clothing rack was placed into the residents room on 01/15/2023. The administrator assistant will complete an audit monthly and check off on a new checklist that every room has the essential needed. Attached is the check list that was made. If any rooms are found without the essentials the administrator will put the essentials within that day.

Directed -
Beginning 2/1/23, the administrative assistant will begin the monthly audit of room requirements.

Directed Completion Date: *02/10/2023*

Implemented [redacted] - 03/07/2023)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 12/20/22 at approximately 10:15 am, there were 4 white, filled trash bags, blocking the exit from the laundry room. The bags were found along the shelving at the doorway. The door had an EXIT sign and had a locked turn knob.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

A sign was posted that nothing can be setting in this area. All doorknobs in the home are now one way lockable. In other words all doors can be opened from the inside by just turning the knob, even if they are locked from the outside. The administrator removed the bags in front of the door on 12/20/2022. Retraining on emergency exits and the need for them to be clear from obstruction will be done on 02/03/2023 by the administrator. Once a month before our monthly meetings the administrative assistant will complete a walkthrough of the buildings to ensure no emergency exits are obstructed. This will begin 02/03/2023 and will be checked off on a monthly checklist.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented [redacted] - 02/14/2023)

132b - Safety Inspection/Fire Drill

8. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and fire drill conducted by a fire safety expert was held on 3/3/2021.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

Rebecca's is having a fire inspection on 02/15/2023 by liberty fire solutions. The administrator has a checklist now that ensures that all fire inspection is on time and done. This checklist will be audited monthly to ensure compliance. This will begin on 02/03/2023 by the administrator

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented [redacted] - 03/07/2023)

133.1 - Exit Signs

9. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

There is an exit sign visible when entering Ritchey Hall into a hallway with resident rooms, however, the door at the end of that hallway, which leads to the exit through the laundry room, has no exit sign indicating that this is an exit. The home currently serves 27 residents.

Plan of Correction ***Directed ([redacted] - 01/31/2023)***

The exit was taken down on the day of inspection due to maintenance painting the hall. The exit sign has been

133.1 - Exit Signs (continued)

replaced and maintenance has been instructed when painting, to paint and immediately replace the signs. The Administrator replaced the sign on 12/21/2023. The administrator will complete a monthly walk through the buildings to ensure that all exit signs are at all exits. The administrator has a checklist that will be completed to erify compliance.

Directed -
Beginning 2/1/23, the administrator will begin the monthly audit.

Directed Completion Date: *02/10/2023*

Implemented [redacted] - 02/14/2023)

141a - Medical Evaluation

10. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #2, admitted on [redacted]22, did not have Documentation of Medical Evaluation (DME) completed within 60 days prior to admission or within 30 days after admission, as the DME was dated [redacted]/21. After admission, the resident did not receive a medical evaluation until [redacted]/22, and the home did not complete the DME form until [redacted]/22.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

Administrator and manager will review all admission documentation to ensure compliance with all allotted dates. Manager will review all current medical evaluations to ensure compliance.

The administrator and administrative assistant will audit all resident files monthly to ensure that residents are in compliance and up to date with all of their paperwork. A checklist was made out on each resident folder to ensure compliance. This began on 01/10/2023.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented ([redacted] - 03/07/2023)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #3's medical evaluation, dated [redacted]/22, did not include the resident's temperature or the medical professional's name and license number.
Resident #7's medical evaluation, dated [redacted]/22, did not include the resident's temperature or immunization history.

Plan of Correction ***Accept ([redacted] - 01/31/2023)***

A new medical evaluation was sent to each residents doctor to be filled out completely with missing information. We are waiting on these documents.

In addition a letter was sent from the owner to the doctors stating that we received violations pertaining to these forms and that the doctors must fill out forms completely.

Administrator and manager will review the forms from the doctors offices to ensure compliance. This began on 01/10/2023.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented [redacted] - 02/14/2023)

185a - Implement Storage Procedures

12. 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 has an order for [redacted]), however this medication was not currently in the home.

Resident's

Plan of Correction ***Accept [redacted] - 01/31/2023)***

Resident 1 has not used the [redacted] and it was listed as a PRN. The medication had since expired and was disposed of. The staff was working on getting this medication discontinued. The medication is currently refilled and in the building. The administrator and manager was told that all medications must be in the building even if they are waiting for a discontinue order from the doctor.
The administrative assistant will audit all the residents' medications monthly to ensure that all the resident's

185a - Implement Storage Procedures (continued)

medication is in the buildings. An audit was completed on 01/22/2023. The medication was reordered on 12/20/2022 and the medication was available on 12/22/2023.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented [redacted] - 02/14/2023)

187a Medication Record

13. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #2 is prescribed [redacted] and [redacted] However, Resident #2's medication administration record (MAR) does not include the staff name/initials of the person administering the medications on [redacted]/22 at [redacted] pm and [redacted]/22 at [redacted] pm.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

Administrator and manager will review the med pass process and every monthly staff meeting. The Care suite system that we use notifies the med tech when an entry is missed. This is a rare occurrence due to the reminder, therefore staff must be more prudent on viewing the notifications. The administrator will audit the MARs monthly to ensure that everyone is in compliance and filling out the MAR the correct way. The administrator is also a med Tech trainer. The audits will begin 02/06/2023. At our next monthly quality management meeting on 02/03/2023 all training will be addressed. All Med Techs will be retrained on 02/10/2023 by the med Tech trainer/ administrator

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented ([redacted] - 02/14/2023)

190a Completion Medication Course

14. Requirements

2600.
190.a. A staff person who has successfully completed a Department approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person B, whose medication administration trainer certification expired on [redacted]/21, and who hasn't been observed or reviewed since, has administered medications to residents including the following:
On [redacted]/22, [redacted]/22, and [redacted]/22 at [redacted] am to Resident #1.

Staff Person D, who last completed a medication observation and review in [redacted]2021, has administered medications to residents including the following:
On [redacted]/22 at [redacted] am to Resident #1.

190a - Completion Medication Course (continued)

Staff Person E, who last completed a medication observation and review in [redacted]/2021, has administered medications to residents including the following:
On [redacted]/22 at [redacted]pm to Resident #1

Plan of Correction ***Accept [redacted] - 01/31/2023)***

The administrator will have her Med Tech Train to trainer completed by 02/01/2023. All Med Techs will have MAR Reviews and observations completed by 02/05/2023 by Med Tech Trainor. The administrator will audit all Med Tech Staff Records to ensure that they are all compliant and up to date. An audit will be done on 02/08/2023 by the administrator and monthly after this. A checklist is produced to check off monthly audit to ensure compliance. With MAR Reviews and observations. The training will be addressed at our quality management meeting on 02/03/2023.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented [redacted] 02/14/2023)

190b - Insulin Injections

15. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On [redacted]/22 at [redacted]pm, Staff Person E, whose last diabetic training was [redacted]/21, administered [redacted] to Resident #3.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

Staff person E received the diabetic training on [redacted]2023. Administrator and manager will review all staff training at every monthly staff meeting to ensure compliance. The administrators will audit the Med Techs to ensure staff are trained and a checklist is made to ensure that all staff comply and up to date. this audit will be completed on 02/09/2023. On 2/03/2023 a quality management staff meeting will be held and address the training that needs to be completed. The administrative assistant will audit the MAR monthly in order to ensure all Mar is being completed properly.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented ([redacted] - 03/07/2023)

225a - Assessment 15 Days

16. 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.

Description of Violation

Resident #2 was admitted on [redacted]/22, but the Resident Assessment-Support Plan (RASP) not completed until [redacted]22.

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept (MD 01/31/2023)***

The administrator and manager will work together in the future reviewing all admission and yearly paperwork to ensure compliance with regulations.

The administrator will completed the RASP within the fifteen day time frame, then the manager will review for compliance.
The administrator and administrative assistant will complete an audit of all current residents to ensure Rasps are in place and completed. The audit will be completed by 02/01/2023. The administrator will do a monthly audit to ensure that Rasps are completed on time. This will begin on 02/20/2023.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented (02/14/2023)

227g -Support Plan Signatures

17. 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 #2's support plan, dated /22, was not signed by the administrator.

Plan of Correction ***Accept 01/31/2023)***

The administrator and manager will work together in the future to double check all admission paperwork and yearly paperwork to ensure compliance with regulations. These forms can be checked every month at staff meetings to ensure compliance.
The administrator assistant will audit the Rasps before our monthly meeting on 02/03/2023

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented - 02/14/2023)

227h - Support Plan Refuse Sign

18. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1 did not sign the most recent annual assessment and support plan. The home did not make a notation regarding the resident's inability or refusal to sign.

Plan of Correction ***Accept - 01/31/2023)***

Administrator and manager will work together in the future double checking all admission and yearly paperwork for compliance with regulations. These forms can be reviewed monthly at staff meetings to ensure compliance.]
The administrator will audit the Rasps to ensure that everything is completed. The first audit will be on 02/03/2023.

Licensee's Proposed Overall Completion Date: *01/30/2023*

Implemented - 02/14/2023)