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

February 22, 2023

[redacted]
UNITED CHURCH OF CHRIST HOMES INC
[redacted]

RE: LEBANON VALLEY HOME
550 EAST MAIN STREET
ANNVILLE, PA, 17003
LICENSE/COC#: 34780

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/26/2023 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: *LEBANON VALLEY HOME* **Licen e #**: *34780* **Licen e Expiration**: *10/07/2023*

Address: *550 EAST MAIN STREET, ANNVILLE, PA 17003*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *UNITED CHURCH OF CHRIST HOMES INC*

Address [redacted]

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

Certificate(s) of Occupancy

Type: *C 1* **Date**: *03/10/1976* **I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *31* **Waking Staff**: *23*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/26/2023*

Inspection Dates and Department Representative

01/26/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *31*

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

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

Inspections / Reviews

01/26/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/09/2023*

02/09/2023 - POC Submission

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

Reviewer [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/15/2023*

Inspections / Reviews *(continued)*

02/10/2023 - POC Submission

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

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

02/22/2023 - Document Submission

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

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

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 1/26/2023 at approximately 9:35 AM, the emergency exit door in the D wing of the home would not open creating a safety hazard in the event of an emergency evacuation. Staff Member A stated the door has been inoperable since 1/24/2023.

Plan of Correction ***Directed (CR - 02/10/2023)***

• The Maintenance Director immediately repaired the D Wing Emergency Exit door on 1/26/23.
• All Emergency Doors were checked and found to be in proper working order by the Maintenance Director on 1/26/23.
• All emergency exit doors will be checked for proper functioning weekly by the Maintenance Assistant and documented on the Fire Door Preventative Maintenance log beginning 2/7/2023.
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.

(Directed)
Beginning on 4/26/2023, the audit results will be reviewed by the QA Committee.

Directed Completion Date: *02/10/2023*

Implemented ([redacted] - 02/22/2023)

132d - Evacuation

2. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 6/22/2022, the fire safety expert specified in writing, that the maximum time to evacuate during a fire drill is 4 minutes and 1 second. The home exceeded the amount of time to evacuate during the following fire drills:
1/12/2022, evacuation time of 4 minutes 18 seconds
2/27/2022, evacuation time of 5 minutes 41 seconds
3/23/2022, evacuation time of 5 minutes 42 seconds
7/19/2022, evacuation time of 4 minutes 13 seconds
8/17/2022, evacuation time of 4 minutes 3 seconds

Plan of Correction ***Directed [redacted] - 02/10/2023)***

• The fire safety expert completed an inspection of the personal care unit to determine the correct maximum safe evacuation time for the home on 2/2/23.
• The document for Fire Evacuation Time/Fire Safe Area Designation was updated by the fire safety expert with an accurate maximum safe evacuation time of 8 minutes and 00 seconds on 2/2/23.

132d - Evacuation (continued)

• Fire drills will continue to be conducted monthly under the direction of the Maintenance Director or designee to ensure resident evacuations are under the maximum safe evacuation time 2/28/23.
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.

• The fire safety expert completed an inspection of the personal care unit to determine the correct maximum safe evacuation time for the home on 2/2/23.
• The document for Fire Evacuation Time/Fire Safe Area Designation was updated by the fire safety expert with an accurate maximum safe evacuation time of 8 minutes and 00 seconds on 2/2/23.
• All residents and staff will be re-educated by the Administrator on the expectations during the evacuation procedures. 2/15/23
• Fire drills will continue to be conducted monthly under the direction of the Maintenance Director or designee to ensure resident evacuations are under the maximum safe evacuation time 2/28/23.
• An audit of the fire drill documentation will be reviewed monthly by the Administrator after each drill to ensure the fire drill process does not exceed the specified time by the fire safety expert. 2/15/23
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.04/26/2023

Directed)

- *f a fire drill evacuation time exceeds the time specified by the fire safety expert, the home will review the fire drill within five days to discuss any obstacles that may have caused the delay in evacuation which will then be reviewed at the QA meetings beginning on 4/26/2023.*

Directed Completion Date: *02/10/2023*

Implemented ([redacted] - 02/17/2023)

162c - Menus Posted

3. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 1/26/2023 at approximately 9:45 AM, the home's menu for the week of 1/15/2023 was posted. However, the home did not have the current week's menu or a menu posted for 1 week in advance.

Plan of Correction ***Directed [redacted] 02/10/2023)***

• The Dining Services Director posted the menus for the current and upcoming week on the bulletin board at the time of the inspection 1/26/2023.
• The Dining Services Director was educated by the Administrator on the procedure for posting menus to include current and following week on 2/2/2023
• The Administrator or designee will audit the postings of menus bi-weekly beginning 2/7/2023.
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.

162c - Menus Posted (continued)

Directed)

Beginning on 4/26/2023, the audit results will be reviewed by the QA Committee.

Directed Completion Date: *02/10/2023*

Implemented (- 02/17/2023)

183b - Meds and Syringes Locked

4. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 1/26/2023 at approximately 4:30 PM, , was unlocked, unattended, and accessible in Resident Room in the wing.

Plan of Correction ***Directed (- 02/10/2023)***

• The medication in room was secured and locked in the resident's medicine cabinet at the time of the inspection by the Licensed Nurse on 1/26/23.
• The Resident was educated by the Administrator on the requirement for medications to be locked in medicine cabinet at all times. Resident verbalized understanding and acknowledged had a key for medicine cabinet on 1/26/23.
• All residents were reeducated by the Licensed Nurse on the importance of keeping medications locked and secured in their medicine cabinet at all times 1/27/2023.
• The Licensed Nurse on each shift will conduct observation audits for residents who self-administer medications to ensure that they are locked and inaccessible.
• Th Administrator will conduct weekly random observation audits for the next three months for those residents who self-administer medications to ensure that meds are locked and inaccessible.2/28/23
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved. February 7,2023 the observation audits began.

(Directed)

- *Beginning on 4/26/2023, the audit results will be reviewed by the QA Committee.*
- *Beginning on 2/7/2023, the Licensed Nurse on each shift will conduct observation audits for residents who self-administer medications to ensure that they are locked and inaccessible.*
- *Beginning on 2/28/2023, the Administrator will conduct weekly random observation audits for the next three months for those residents who self-administer medications to ensure that meds are locked and inaccessible.*

Directed Completion Date: *02/28/2023*

Implemented (- 02/22/2023)

185a - Implement Storage Procedures

5. Requirements

185a - Implement Storage Procedures *(continued)*

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

On 1/26/2023 at approximately 3:09 PM, Resident #1's glucometer was not calibrated to the correct time or date.

Plan of Correction ***Directed (- 02/10/2023)***

• Resident 1's glucometer was recalibrated to the correct time and date by the Licensed Nurse on 1/26/2023.
• All resident glucometers were evaluated by the Licensed Nurse to ensure all were calibrated to correct date and time 1/26/2023.
• Licensed staff were educated by the Administrator on inspecting each glucometer prior to doing a resident blood glucose and when replacing a battery in the glucometer on 2/6/2023.
• Administrator will audit all resident glucometers once a month to ensure that the correct date and time is displayed. The audits will begin 2/20/2023.
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.

Directed)
Beginning on 4/26/2023, the audit results will be reviewed by the QA Committee.

Directed Completion Date: *02/20/2023*

Implemented (- 02/22/2023)

224a - Preadmission Screen Form

6. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening, dated /2022, did not include safety needs (such as staffing, fire safety) and health needs (such as medication administration).

Plan of Correction ***Directed - 02/10/2023)***

• Resident 2's preadmission screening was completed, and the appropriate boxes checked by the Licensed Nurse to reflect the safety and health needs of the resident 1/26/2023.
• Upon completion of all preadmission screenings, the form will be double checked by the day shift Licensed Practical Nurse or designee to ensure completion within twenty-four hours. 2/1/2023
• An audit by the Administrator or designee will be completed monthly for all new admission screening forms to ensure each resident's needs are identified and the screening form is completed in entirety. 2/28/23
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.

Directed)
Beginning on 4/26/2023, the audit results will be reviewed by the QA Committee.

Directed Completion Date: *02/28/2023*

Implemented (02/17/2023)

227g -Support Plan Signatures

7. 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 #3's support plan, dated [redacted] 2022, was not signed by the resident, who participated in its development. The resident's record did not include a notation that the resident was unable or refused to sign the plan.

Plan of Correction ***Directed ([redacted] - 02/10/2023)***

• Resident 3's support plan that was dated [redacted] /2022 was updated with the resident's signature or [redacted] /2023.
• All resident charts will be reviewed to ensure all signatures are captured, if the resident is unable or refuses to sign the appropriate box is checked. 2/7/2023
• Administrator will provide education to all licensed staff on making sure the appropriate box is checked if a resident is unable or refuses to sign their support plan 2/6/2023.
• Administrator will audit all charts once a month to ensure that licensed nursing staff are completing the support plan with resident signature or correct box is being checked 2/7/2023.
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.

PCHA or LPN will audit all charts monthly

(Directed)
Beginning on 4/26/2023, the audit results will be reviewed by the QA Committee.

Directed Completion Date: *02/10/2023*

Implemented [redacted] 02/22/2023)

253c - Records Log

8. Requirements

2600.
253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident's name, record number, birth date, admission date and discharge date.

Description of Violation

Resident #4's record was destroyed on [redacted] /2022; however, the log of resident records destroyed does not include Resident #4's date of discharge.

Resident #5 's record was destroyed on [redacted] 2022; however, the log of resident records destroyed does not include Resident #5's date of discharge.

Resident #6's record was destroyed on [redacted] /2022; however, the log of resident records destroyed does not include Resident #6's date of discharge.

253c - Records Log (continued)

Plan of Correction ***Accept (CR - 02/10/2023)***

• The discharge dates will be added to destruction records for Residents 4, 5 and 6 on [redacted]/2023.
• The Administrator revised old destruction record log to include discharge date of all discharged residents moving forward.1/26/23
• Administrator will audit discharge logs quarterly to ensure they are completed in entirety and include the discharge date.
• The Administrator will report the audit results to the QA Committee until a pattern of compliance is achieved.

Quarterly audits will begin 4/1/23 by the administrator.
QA meeting is scheduled April 26, 2023

Licensee's Proposed Overall Completion Date: *02/10/2023*

Implemented [redacted] - 02/17/2023)