

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

August 28, 2023

[REDACTED], ADMINISTRATOR  
RENAISSANCE HOME PINEBROOK LLC  
[REDACTED]

RE: RENAISSANCE HOME PINEBROOK  
2 WOODBRIDGE ROAD  
ORWIGSBURG, PA, 17961  
LICENSE/COC#: 22755

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/19/2023, 04/20/2023 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: RENAISSANCE HOME PINEBROOK License #: 22755 License Expiration: 05/20/2024
Address: 2 WOODBRIDGE ROAD, ORWIGSBURG, PA 17961
County: SCHUYLKILL Region: NORTHEAST

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: RENAISSANCE HOME PINEBROOK LLC
Address: [Redacted]

Certificate(s) of Occupancy

Type: I-2 Date: 08/28/2018 Issued By: West Brunswick Twp.

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 40 Waking Staff: 30

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Complaint Exit Conference Date: 04/20/2023

Inspection Dates and Department Representative

04/19/2023 - On-Site: [Redacted]
04/20/2023 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

Table with 4 columns: Category, Value, Category, Value. Rows include License Capacity (68), Residents Served (39), Secured Dementia Care Unit (In Home: No, Area, Capacity, Residents Served), Hospice (Current Residents: 0), and Number of Residents Who (Receive Supplemental Security Income: 3, Are 60 Years of Age or Older: 39, Diagnosed with Mental Illness: 6, Diagnosed with Intellectual Disability: 1, Have Mobility Need: 1, Have Physical Disability: 1).

Inspections / Reviews

Table with 3 columns: Date/Type, Lead Inspector, Follow-Up Type, Follow-Up Date. Rows include 04/19/2023 Full (Lead Inspector: [Redacted], Follow-Up Type: POC Submission, Follow-Up Date: 05/21/2023) and 06/06/2023 - POC Submission (Submitted By: [Redacted], Date Submitted: 06/30/2023, Reviewer: [Redacted], Follow-Up Type: POC Submission, Follow-Up Date: 06/12/2023).

Inspections / Reviews *(continued)*

06/16/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/30/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 07/03/2023

08/28/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/30/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

18 - Compliance With Laws

1. 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

The carbon monoxide detector located in the resident's dining room did not have the batteries dated. Unable to determine when the batteries were changed.

Plan of Correction

Accept (████) - 06/06/2023)

Batteries in carbon monoxide detectors are monitored weekly by the maintenance director and changed when needed. The batteries in this detector were changed on 04/20/2023 and dated.

Please see attached.

Ongoing compliance will be monitored by the Administrator.

Licensee's Proposed Overall Completion Date: 06/02/2023

Implemented (████) - 08/18/2023)

42s - Privacy

2. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home utilizes video recording in facility, but no signage was posted making the residents and visitors in the facility aware of this activity.

Plan of Correction

Accept (████) - 06/16/2023)

See attached.

We do have a Ring camera system installed at the main entrance. The system is not functional. The notice is posted on the window at the main entrance.

Our IT will be providing us with the proper computer equipment to enable us to properly use the Ring System. Once the Ring System is in place and functioning properly the Administrator and IT department will monitor ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/15/2023

Implemented (████) - 08/18/2023)

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, ██████████, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

54a Direct Care Staff (continued)

Plan of Correction

Accept ( ) - 06/16/2023)

See attached.

The diploma for this employee was noted to be in the file for her sister who was also employed here. This was shown to the inspector a few mins prior to the exit interview.

The administrator will ensure that employee files are audited and appropriate documentation is in the correct file and ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/15/2023

Implemented ( ) - 08/18/2023)

65f - Training Topics

4. 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.

Description of Violation

The home did not provide direct care staff training for training year 2022 in the following areas:

- 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.

Plan of Correction

Accept ( ) - 06/16/2023)

This training is was provided for staff in the 2022 Relias Trainings.

Please see attached paragraph taken from Relias:

Person centered service plans help to direct individualized care for each resident in assisted living facilities or ALFs. Through person centered plans, staff can direct and provide quality, individualized care to the residents they serve. This course discusses the purpose and importance of person centered service plans and how they are implemented. It also discusses how the staff will use these service plans. Without individual service plans, or ISPs, important care concerns may not be carried out.

Corporate RN Educator provided the the documentation and the Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/15/2023

Implemented ( ) - 08/18/2023)

109b - Rabies Vaccination

5. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

Resident's #1 and #2, pet cat had an expired vaccination record dated 10/04/22.

Plan of Correction

Directed (████) - 06/16/2023)

The resident will provide the current vaccination record after the pet is seen by the Veterinarian in July 2023. I will forward the documentation when it is available after the vet appointment.

The administrator will monitor for ongoing compliance.

**Within 15 days of the directed plan of correction:**

**The home will produce documentation or rabies vaccination for the identified animal. If such documentation cannot be obtained, the animal will be removed from the home.**

Directed Completion Date: 07/01/2023

Implemented (████) - 08/18/2023)

132b Safety Inspection/Fire Drill

6. 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 home has not completed a fire safety inspection or fire drill since 2019.

Plan of Correction

Directed (████) - 06/16/2023)

The fire Safety inspection will be conducted by Crocker Fire Safety. I will provide all documentation when it becomes available. The date of the inspection has not been given to the Administrator yet. I will report the date when available.

The administrator is responsible for fixing the problem and will monitor for ongoing compliance.

**Within 15 days of the directed plan of correction:**

**The administrator will ensure that a fire safety inspection and fire drill are conducted by a fire safety expert. Documentation of the inspection and drill will be kept.**

Directed Completion Date: 07/01/2023

Implemented (████) - 08/28/2023)

132d Evacuation

7. Requirements

2600.

132d - Evacuation (continued)

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**

*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.*

*The home didn't have a letter from a fire safety expert to extend the times of their fire drill evacuations. The homes evacuation times are as follows:*

- 5/22/22. 6/15/22 6 mins 0 seconds*
- 7/1/22 2 mins 55 seconds*
- 8/19/22 3 mins 55 seconds*
- 10/11/22 7 mins 4 seconds*
- 11/25/22 3 mins 21 seconds*
- 12/20/22 4 mins 8 seconds*
- 1/6/23 4mins 19 seconds*
- 2/15/23 4mins 6 seconds*
- 3/8/23 5 mins. 8 seconds*
- 4/17/23 4 mins and 16 seconds*

**Plan of Correction**

*Directed (████ - 06/16/2023)*

*We are currently working with Crocker Fire Safety to complete a Fire Safety Inspection and to improve the evacuation times.*

*The Administrator will continue to accomplish this goal and become compliant.*

*The Maintenance Director and the Administrator will fix the problem. The administrator is responsible for ongoing compliance.*

**Within 15 days of receipt of this plan of correction:**

***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.***

***Residents who are unable to evacuate the home within 2 1/2 minutes, shall be discharged from the home. The administrator is responsible for monitoring and ongoing compliance.***

Directed Completion Date: 07/01/2023

*Implemented (████ - 08/28/2023)*

141a 1-10 Medical Evaluation Information

**8. 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 DME dated [REDACTED] and resident #4's DME dated [REDACTED] did not have their medication listed or attached to their medical evaluation forms.

**Plan of Correction**

Accept ( [REDACTED] ) - 06/16/2023)

Physicians orders were reviewed with provider and signed and dated, and attached to the current DME. This was corrected on 05/02/2023

The Director of Wellness is responsible for fixing the problem.

The administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/15/2023

Implemented ( [REDACTED] ) - 08/18/2023)

183f - Discontinued Medications

**9. Requirements**

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident’s medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

**Description of Violation**

Resident #5's [REDACTED] vial had a date opened [REDACTED]. The manufacture’s direction is to discard after being opened 28 days.

Resident #6 had 2 vials of [REDACTED] vials that 1 date opened [REDACTED] and one dated opened [REDACTED]. The manufactures directions are to discard after 31 days of being opened.

**Plan of Correction**

Accept ( [REDACTED] ) - 06/16/2023)

The vials of insulin were immediately disposed of and new vials were opened and dated 04/20/2023.

The Director of Wellness is responsible for the med cart audits.

Reviewed with staff the importance of monitoring the dates on the insulin vials during med cart audits.

The Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/15/2023

Implemented ( [REDACTED] ) - 08/18/2023)

185a - Implement Storage Procedures

10. 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 #5's Glucometer had a blood sugar result on [REDACTED] was recorded on the resident's MAR.

Plan of Correction

Accept [REDACTED] - 06/16/2023)

The Director of Wellness reviewed the glucometer results in the MAR on [REDACTED]. Based on the slight difference in result it was noted that there would not have been any error in the amount of sliding scale insulin coverage that was administered.

Bi-monthly audits are completed on the glucometers. Audits are completed by the Director of Wellness.

The administrator will monitor audits done by the DOW for ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/15/2023

Implemented [REDACTED] - 08/18/2023)

252 - Record Content

11. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

26. A termination notice, if any.

Description of Violation

Resident #7 DOA [REDACTED] Resident #8 DOA [REDACTED] records, did not state if the residents had any identifiable marks.

Plan of Correction

Directed [REDACTED] - 06/16/2023)

There is only 6 residents listed. There is not a resident #7 or #8 to refer to and make the necessary corrections.

Please see above description of violation.

Again Resident #7 and Resident #8 are not listed.

**Within 15 days of receipt of this plan of correction:**

**Resident # 6 - [REDACTED]**

**Resident # 7 - [REDACTED]**

**Violations discussed at exit conference on 4-20-23.**

**The administrator will review audit all resident records to ensure that all of the information required by this regulation is present. Missing information will be added immediately. The administrator shall monitor and be responsible for ongoing compliance.**

Directed Completion Date: 07/01/2023

Implemented [REDACTED] - 08/18/2023)