

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

June 21, 2023

[REDACTED], ADMINISTRATOR
EAGLE VALLEY PERSONAL CARE HOME INC
500 FRONT STREET, PO BOX 8969
MILESBURG, PA, 16853

RE: EAGLE VALLEY PERSONAL CARE
HOME
500 FRONT STREET
MILESBURG, PA, 16853
LICENSE/COC#: 22743

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/17/2023, 05/18/2023 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: EAGLE VALLEY PERSONAL CARE HOME License #: 22743 License Expiration: 05/25/2024
 Address: 500 FRONT STREET, MILESBURG, PA 16853
 County: CENTRE Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: EAGLE VALLEY PERSONAL CARE HOME INC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 01/08/2008 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 54 Waking Staff: 41

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Incident Exit Conference Date: 05/18/2023

Inspection Dates and Department Representative

05/17/2023 - On-Site: [REDACTED]
 05/18/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 60 Residents Served: 50
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 5
 Number of Residents Who:
 Receive Supplemental Security Income: 2 Are 60 Years of Age or Older: 48
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 4 Have Physical Disability: 0

Inspections / Reviews

05/17/2023 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/18/2023

06/16/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 06/20/2023
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/20/2023

Inspections / Reviews *(continued)*

06/20/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/20/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/23/2023

06/21/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/20/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

103i - Outdated Food

1. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

A zip lock bag of breakfast sausage was in the main kitchen freezer. The sausage was not labeled with a date.

Plan of Correction

Accept (████) - 06/20/2023)

Staff has been re-educated on policy J 1 "Food safety and sanitation policies." I have attached the policy and record of training.

The Food Service Director is responsible for removing food from the refrigerator or freezer that has not been correctly labeled. The Administrator immediately corrected the instance identified by the surveyor by asking the food service worker assigned to breakfast when the sausage was opened. She indicated the sausage had just been opened that morning. The sausage was identified correctly with the date and food item name.

The Administrator reviewed the policy to ensure it had instructions for labeling food items removed from the original packaging.

The staff was re-educated on the policy; see the record of training attached. The Food Service Director will scan the refrigerators/ freezers daily to ensure all items are labeled correctly.

Licensee's Proposed Overall Completion Date: 06/19/2023

Implemented (████) - 06/21/2023)

132c - Fire Drill Records

2. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

On 10/18/23, the home conducted a fire drill. The route of evacuation was not documented.

Plan of Correction

Accept (████) - 06/20/2023)

This administrator will review all fire drill records within 72 hours of drill to ensure the drill was completed; date of drill, time of drill, amount of time to evacuate, exit route(s) used, # of residents in home (at time of alarm sounds), # of residents evacuated, # of staff participating, was alarm activated, was alarm operative, any problems, and planned corrective actions.

The Administrator is responsible for ensuring documentation accuracy on the fire drill log.

The Administrator will monitor for ongoing compliance by reviewing the record of a fire drill within 72 hours to ensure accurate and complete documentation of the event. The Administrator will initial and date the entry.

The Administrator met with the evening shift supervisor who conducted the drill on 10/18/2023. The Administrator educated the supervisor on the omission of the blocked exit route.

Licensee's Proposed Overall Completion Date: 06/19/2023

Implemented (████) - 06/21/2023)

141a 1-10 Medical Evaluation Information

3. 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. 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 #1's medical evaluation dated [redacted] did not include residents' height. Resident #2's medical evaluation dated [redacted] did not include residents' height, weight, pulse, blood pressure, or temperature.

Plan of Correction

Accept [redacted] - 06/20/2023)

Policy A 5 has been reviewed and update. Updated portion has been highlighted on the attached copy. All team leaders, supervisors, administrative assistant and this administrator have all reviewed and signed off.

The Resident Care Coordinator completed the DMEs identified by the surveyor during the inspection on 5/18/2023.

The Resident Care Coordinator(RCC) is responsible for ensuring all DMEs are complete. The department-approved sections should be completed by the RCC. Any other section not completed should be returned to the physician with an explanation as to why.

The Administrator will monitor all DMEs within 72 hours to ensure on-going compliance.

Licensee's Proposed Overall Completion Date: 06/19/2023

Implemented [redacted] - 06/21/2023)

185a Implement Storage Procedures

4. 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 incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #3 – At [redacted] on [redacted] the reading on the glucometer was [redacted] but was incorrectly transcribed as [redacted].

Plan of Correction

Accept [redacted] - 06/20/2023)

Policy H 15 procedure for Blood Sugars has been reviewed, updated and staff have been re-educated on the updates. See attached policy and record of education. This administrator or designee weekly will conduct MAR and Glucometer audits to ensure accurate documentation.

The Resident Care Coordinator corrected the transcription error on the identified resident's chart by adding a late entry note on 5/18/2023 clarifying the correct number. The difference between the documented 117 and 119 did not result in a medication error. However, the importance of accurate log entries is the issue.

The Administrator has developed a monitoring tool to examine the data entry log vs the monitor. No less than 50% of the blood glucose tests done monthly will be compared for accuracy.

185a Implement Storage Procedures (continued)

Any errors identified will result in all of that individual's blood glucose tests being looked at for the month. The individual who made the error will not be permitted to continue doing blood glucose tests before being reeducated by the diabetes educator.

The Administrator will monitor for ongoing compliance with the plan.

Licensee's Proposed Overall Completion Date: 06/19/2023

Implemented ([REDACTED] - 06/21/2023)