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

November 9, 2023

[redacted], PERSONAL CARE ADMINISTRATOR
PENSTATE BEST CARE INC
[redacted]

RE: HASKINS HOUSE
1009 RHOADS AVENUE
SECANE, PA, 19018
LICENSE/COC#: 13855

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/02/2023, 06/21/2023, 06/23/2023 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: *HASKINS HOUSE* **License #**: *13855* **License Expiration**: *07/05/2023*

Address: *1009 RHOADS AVENUE, SECANE, PA 19018*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

Name: *Sonja Maher* **Phone**: *6106233624* **Email**: *penstatebest@gmail.com*

Legal Entity

Name: *PENSTATE BEST CARE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/28/1997* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *22* **Waking Staff**: *17*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *06/23/2023*

Inspection Dates and Department Representative

06/02/2023 - On-Site [redacted]

06/21/2023 - Off-Site

06/23/2023 - Off-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *22* **Residents Served**: *19*

Secured Dementia Care Unit

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

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older**: *16*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability**: *3*

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

06/02/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/20/2023*

Inspections / Reviews *(continued)*

07/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/03/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/01/2023*

08/08/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/03/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/01/2023*

11/09/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/03/2023*

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

On [redacted] Resident #1 called the police to the home because [redacted] was upset. The officers responded to the call and arrived to the home. However, the resident who made the complaint was not available at the time of the response. The home did not report this incident to the department.

Plan of Correction ***Directed [redacted] - 08/08/2023)***

I disagree with this violation. On [redacted] I was on duty at facility from 730am to 10pm and there was no police responding to facility. On [redacted] I spoke with Officer [redacted] and was informed that there was not a call from our facility nor was there any officer dispatched to the facility. The home shall report any incident to dept within 24 hr of incident. Administrator to ensure reportable incident report is sent to DHS within 24hr of incident. Resident care plan was adjusted by administrator on 6/6/23 to reflect residents behavior issues.

Directed Plan of Correction 8/8/23 [redacted]:

Within 30 days of receipt of the plan of correction: All staff persons will be educated on the home's policy and procedures for reportable incidents and conditions including the reporting requirements. Documentation of education shall be kept.

Immediately, the administrator shall review all reportable incidents and conditions at least weekly to ensure all reportable incidents and conditions are reported to the Department in accordance with regulation 2600.16c.

Directed Completion Date: *09/01/2023*

Implemented ([redacted] - 11/09/2023)

187a - Medication Record

2. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

187a Medication Record *(continued)*

Description of Violation

Resident #1 is prescribed [redacted]. This medication has not been administered. It is not included on resident #1's medication administration record.

Plan of Correction ***Accept ([redacted] - 08/08/2023)***

Administrator/LPN removed medication on 6/2/23. Administrator completed medication audits for all residents on 7/1/23. Administrator will continue to conduct medication audits monthly at time of MAR change over.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented [redacted] - 11/09/2023)

3. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.

Description of Violation

Resident #1 is prescribed [redacted]. The order reads as follows:

[redacted], inject subcutaneously, [redacted] units at bedtime.

However, resident's #1 medication administration record does not indicate the following components:

- *Name of medication*
- *Strength*
- *Dosage form*
- *Dose*
- *Route of administration*
- *Frequency*

Plan of Correction ***Accept ([redacted] - 07/27/2023)***

Administrator corrected route of medication and diagnosis on 6/2/23. Administrator to check MARS at the beginning of the month before change over of the MARS take place for for upcoming month to make sure that all medications on MAR have all components of medication administration. On 6/5/23 administrator spoke with pharmacy to let them know purpose of medication instructions and diagnosis.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ([redacted] - 11/09/2023)

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

Resident #1 has a prescribed order for glucose checks 4 times daily. However, resident #1 did not have the glucose checks on the following days:

- [redacted]

Plan of Correction ***Directed ([redacted] - 08/08/2023)***

Resident refused [redacted] medication and glucose check on those days. It was recorded of medication MAR however not done on glucose MAR. Resident RASP updated on 6/6/23 to reflect that behavior and [redacted] being out of facility will result in no glucose number. Administrator to ensure that medication is given as prescribed by MD and noted if that is not able to be done. Resident is currently seeing a therapist [redacted] had seen in the past. [redacted] had seen psychiatry via televisit monthly. Now resident having weekly sessions in person. [redacted] family is paying out of pocket for [redacted] to see therapist weekly. The sessions appear to be helping resident. I understand that steps need to be taken to follow regulation, however this particular resident issues are unique and are long standing and physician and family are aware of his issues. [redacted] will take medication as ordered for long periods at a time and then for some reason his behavior changes. [redacted] care plan notes his behavior issues. The facility does have noncompliant with medication or refusal to cooperate with medical care as a discharge criteria. Currently resident is taking medications as ordered and doing well with weekly physiatrist visits.

Directed Plan of Correction 8/8/23 [redacted]:

Within 30 days of receipt of the plan of correction, the administrator shall review and update if necessary the home's procedures for the safe storage, access, security, distribution and use of medications, including the procedures for ensuring all prescribed medications are available in the home for administration and the procedures for ordering prescribed medications. All staff persons qualified to administer medications shall be reeducated on the home's policy and procedures. Documentation of education shall be kept.

Within 30 days of receipt of the plan of correction The administrator or designee shall conduct an audit of prescription orders and medications weekly for four weeks then biweekly for all residents, to ensure proper documentation of medication administration, following the orders of the prescriber and reporting medication errors.

Directed Completion Date: *09/01/2023*

Implemented ([redacted] - 11/09/2023)

188b - Medication Error Reporting

5. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

188b - Medication Error Reporting *(continued)*

Description of Violation

Resident #1 has an order for prescribed glucose checks 4 times daily. However, resident #1 , did not have the glucose checks on the following days:

- [redacted]

The medication error was not reported to the designated person and prescriber.

Plan of Correction ***Directed ([redacted] - 08/08/2023)***

Resident refused medication and glucose monitoring on those days. It was noted on MAR of refusal of medication however not on glucose monitoring mar. MD was aware of medication refusal and glucose monitoring refusal. Resident family was also aware of refusal. Administrator informed nursing staff to note refusal on glucose monitoring MAR. Md had been notified of refusal of medication and was noted on Med MAR just not on glucose monitoring MAR. Family was also informed of his refusal. Staff will put refusal on glucose monitoring sheet in addition to medication MAR. Staff will record notification to family on MAR in addition to MD notification.

Directed Plan of Correction 8/8/23 [redacted]:

Within 30 days of the receipt of the accepted plan of correction, the administrator or designated staff person qualified to administer medications will develop and implement a process and procedure to ensure all medication refusals and errors are properly reported. All staff shall be trained on the procedure

Starting 8/9/23, the administrator shall monitor medication administration at least twice a week and monitor all resident MARs at least weekly, for a period of two months, to ensure any medication refusals and errors are properly reported.

Directed Completion Date: *09/01/2023*

Implemented ([redacted] - 11/09/2023)

225c - Additional Assessment

6. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #1 's most recent assessment was completed on [redacted]. The annual assessment was not available on [redacted]

Plan of Correction ***Directed ([redacted] - 08/08/2023)***

Resident assessment completed on [redacted] Administrator to audit resident records monthly to ensure ongoing compliance. Administrator completed audit of resident records on 7/1/23. Administrator will complete monthly

225c - Additional Assessment (continued)

audits of resident records every month.

Directed Plan of Correction 8/8/23 [redacted]:

Within 30 days of the receipt of the accepted plan of correction, the administrator will develop and implement a process and procedure to ensure all resident assessments are completed within the required time frame and are complete and accurate including all resident diagnoses. Staff involved in the assessment of residents shall receiving training on this process.

Beginning 8/9/23 and continuing monthly for 6 months, the administrator shall complete an audit of resident records to ensure timely completion of support plans.

Directed Completion Date: *09/01/2023*

Implemented [redacted] - 11/09/2023)

227d - Support Plan Medical/Dental

7. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for Resident #1, dated [redacted] does not indicates the resident has a need for the following:

- *Managing finances : Resident #1 has a guardian to assist with finances*
- *Maintaining consistency with glucose checks for proper insulin dosage*
- *Verbally aggressive behaviors*

The resident's support plan, dated 3-12-22, does not document how this need will be met.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Resident care plan completed on [redacted] Support plan includes resident behavior issues and guardian financial responsibility. Administrator to do monthly audit to ensure ongoing compliance. Administrator updated the resident support plan on [redacted] Administrator will audit residents charts to ensure all needs are documented in plan. Administrator to perform monthly audits of residents charts to ensure are complete. Administrator to start on 7/1/23 and continue chart audits monthly.

Licensee's Proposed Overall Completion Date: *08/01/2023*

Implemented ([redacted] - 11/09/2023)

251b - Record Entries Legible

8. Requirements

2600.

251b Record Entries Legible *(continued)*

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The signatures and documentation on the Medication Administration Record for resident #1 is not legible. The initials of the administer and the numeral documentation are not legible for the month of May . This information is located under the sliding scale directives.

Plan of Correction ***Accept ([redacted] - 08/08/2023)***

I disagree with this violation. We have separate boxes for glucose numbers. Yes there are numbers missing however that has been addressed in previous violation. I feel numbers are clear and legible. The order it is staff initials on top, then glucose number and then coverage. Administrator to do monthly audits to ensure that entries are dated and signed by staff. On 7/31/23 administrator contacted pharmacy to ensure future MARs have 2 boxes for 8a, 1130, and 5p glucose monitoring to ensure all entered data is legible.
Administrator corrected MAR to have 2 boxes instead of one box to have space for each glucose number, initials and coverage. Change ensures space for legible initials, glucose number and coverage. Mar with change starts on 8/1/23.

Licensee's Proposed Overall Completion Date: *08/01/2023*

Implemented [redacted] - 11/09/2023)