

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

August 15, 2023

[REDACTED], ADMINISTRATOR
PHOEBE RICHLAND HEALTH CARE CENTER
108 SOUTH MAIN STREET
RICHLANDTOWN, PA, 18955

RE: MEADOW GLEN AT PHOEBE
RICHLAND
108 SOUTH MAIN STREET
RICHLANDTOWN, PA, 18955
LICENSE/COC#: 14225

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/21/2023, 06/22/2023 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: MEADOW GLEN AT PHOEBE RICHLAND License #: 14225 License Expiration: 02/08/2024
Address: 108 SOUTH MAIN STREET, RICHLANDTOWN, PA 18955
County: BUCKS Region: SOUTHEAST

Administrator

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

Legal Entity

Name: PHOEBE RICHLAND HEALTH CARE CENTER
Address: 108 SOUTH MAIN STREET, RICHLANDTOWN, PA, 18955
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: 1 2 Date: 11/30/2015 Issued By: Richlandtown Borough

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 123 Waking Staff: 92

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Complaint, Incident Exit Conference Date: 06/22/2023

Inspection Dates and Department Representative

06/21/2023 On Site [Redacted]
06/22/2023 On Site [Redacted]

Resident Demographic Data as of Inspection Dates

Table with 4 columns: Category, Value 1, Value 2, Value 3. Rows include General Information (License Capacity: 100, Residents Served: 78), Secured Dementia Care Unit (In Home: Yes, Area: Memory Support, Capacity: 40, Residents Served: 34), Hospice (Current Residents: 3), and Number of Residents Who (Receive Supplemental Security Income: 0, Are 60 Years of Age or Older: 77, Diagnosed with Mental Illness: 18, Diagnosed with Intellectual Disability: 0, Have Mobility Need: 45, Have Physical Disability: 1).

Inspections / Reviews

Table with 3 columns: Date/Type, Lead Inspector, Follow-Up Type, Follow-Up Date. Rows include 06/21/2023 - Full (Lead Inspector: [Redacted], Follow-Up Type: POC Submission, Follow-Up Date: 07/16/2023) and 07/18/2023 - POC Submission (Submitted By: [Redacted], Date Submitted: 08/09/2023, Reviewer: [Redacted], Follow-Up Type: POC Submission, Follow-Up Date: 07/23/2023).

Inspections / Reviews *(continued)*

07/25/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/09/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 08/24/2023

08/15/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/09/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

42c - Treatment of Residents

1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [REDACTED] 23, at approximately [REDACTED] pm, Staff person A arrived in the activities room of Memory Support Unit A and proceeded to set up their cellphone on the corner ledge near the radio, positioning it about 6-7 feet away from the table where Resident 1 and other residents were engaged in activities. Staff person A then recorded themselves and resident 1 as Staff person A initiated a brief conversation with the resident, then proceeded to remove Resident 1's wig without obtaining consent to do so. This is a violation of resident 1's right to privacy and dignity/respect. Staff person A also disregarded Resident 1's personal boundaries when they proceeded to play with or run their fingers through Resident 1's hair multiple times, before replacing the wig back onto Resident 1's head. The video was later shared by Staff person A with other persons outside of the home and via a social media site, violating the residents right to dignity, respect and privacy.

Plan of Correction

Accept ([REDACTED] - 07/25/2023)

Staff member A's employment was terminated on [REDACTED] once facility became aware of the video. Upon interview, Resident #1 had no recollection of the event and has not had any noted change in status or behavior. PCHA/designee will educate staff on regulation 2600.42c and the treatment of residents by July 19th. Beginning July 20th, PCHA/designee will complete five random resident interviews/staff observations to evaluate resident rights are being maintained, per week, for two weeks, to ensure compliance of regulation 2600.42c is maintained. Results and trends will be shared with the Quality Assurance Committee.

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

Implemented ([REDACTED] - 08/15/2023)

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

On [REDACTED] /23, at approximately [REDACTED] pm, Staff person A arrived in the activities room of Memory Support Unit A and proceeded to set up their cellphone on the corner ledge near the radio, positioning it about 6-7 feet away from the table where Resident 1 and other residents were engaged in activities. Staff person A set their phone to record themselves and resident 1 as Staff person A proceeded to remove Resident 1's wig without obtaining consent to do so. This is a violation of resident 1's right to privacy. The video was later shared by Staff person A with other persons outside of the home and via a social media site again, violating the residents right to privacy.

Plan of Correction

Accept ([REDACTED] - 07/25/2023)

Staff member A's employment was terminated on [REDACTED] once facility became aware of the video. Upon interview, Resident #1 had no recollection of the event and has not had any noted change in status or behavior. Staff members will be educated by PCHA/designee on regulation 2600.42s and the right of privacy by July 19th. Beginning July 20th, PCHA/designee will complete five random resident interviews/staff observations to evaluate resident privacy is being maintained, per week, for two weeks, to ensure compliance of regulation 2600.42s is maintained. Results and trends will be shared with the Quality Assurance Committee.

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

42s - Privacy (continued)

Implemented [redacted] 08/15/2023)

51 - Criminal Background Check

3. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person B, whose first day of work was [redacted], did not have a background check completed prior to their first day of work. Background check on file was completed on [redacted]

Plan of Correction

Accept [redacted] - 07/25/2023)

Staff person B employment was terminated on [redacted]. Moving forward, Dietary employees will not start employment until an actual copy of the PATCH report is received. PCHA/designee will educate Dining Manager/designees on the regulation 2600.51 of ensuring that PA State Police background results are received prior their first date of employment by July 19, 2023. Random audits will begin July 20th of new hire background checks, for two weeks by the PCHA/designee, with results and trends reported to quality assurance committee.

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

Implemented [redacted] 08/15/2023)

65g - Annual Training Content

4. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person A, Staff person C, Staff person D, and Staff person E did not receive training on fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2022.

Plan of Correction

Accept [redacted] - 07/25/2023)

Staff members C, D and E received annual fire training by a fire safety trainer by 8/8/2023. Staff member A s employment has been terminated. Staff fire safety training will be completed by a fire safety trainer by 8/8/2023. Moving forward, fire trainings will be completed be an onsite fire safety trainer annually. PCHA/designee will complete an audit of the onsite fire safety training attendance record to ensure current employees have attended by 8/9/2023. Additional staff members have received fire safety train the trainer certificates on 7/19/2023 to be an onsite fire safety trainer.

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

Implemented [redacted] - 08/15/2023)

91 - Telephone Numbers

5. Requirements

91 - Telephone Numbers (continued)

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in Memory Support A kitchen.

Plan of Correction

Accept () - 07/25/2023)

Emergency list of phone numbers was added to the landline in the Memory Support A Kitchen on 6/21/2023 @ noon. Audit of telephones in the facility was completed on 6/23/2023 and no further telephones were identified as missing emergency phone numbers. PCHA/designee will educate nursing and community life staff of the regulation 2600.90a by July 19, 2023. Beginning July 20th, PCHA/designee will audit five random phones in the facility, for two weeks, to ensure that emergency phone numbers are listed. Results and trends will be reported to Quality Assurance Committee.

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

Implemented () - 08/15/2023)

103f - Refrigerator/Freezer Temps

6. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 6/21/23 at 10:30am, the temperature in the Memory Support B freezer was 10 degrees Fahrenheit.

On 6/21/23 at 10:40am, the temperature in the Memory Support A fridge was 46 degrees Fahrenheit.

On 6/21/23 at 10:51am, the temperature in the 2nd floor activities room freezer was 10 degrees Fahrenheit.

Plan of Correction

Accept () - 07/25/2023)

On 6/22/2023, the thermometers of the cited refrigerators and freezers read temperatures that were in compliance with regulation 2600.103f. Other freezers/refrigerators were examined by Food Service Director on June 22, 2023, and were displaying temperatures within regulation. PCHA/designee will educate dining and nursing staff on regulation 2600.103f by July 19, 2023. Beginning July 20th, PCHA and/or designee will audit 5 fridges/freezers weekly, for two weeks, and to ensure the thermometers are displaying temperatures within regulation.

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

Implemented () 08/15/2023)

107d - Procedure Emergency Management Agency Submission

7. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

107d - Procedure Emergency Management Agency Submission (continued)

Description of Violation

The home has no documentation of sending the emergency procedures to the local emergency management agency.

Plan of Correction

Accept () - 07/25/2023)

2023 Emergency Preparedness Manual will be sent to Bucks County Emergency Services via certified mail with returned receipt by July 19th by PCHA/designee. Moving forward, this will be the practice of notifying the Bucks County Emergency Services annually by PCHA/designee. Current PCHA calendar has been updated for June 1, 2024 to send Emergency Preparedness Manual to Bucks County Emergency Services.

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

Implemented () - 08/15/2023)

132c - Fire Drill Records

8. 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

The fire drill record for the drill conducted on 10/31/22 at 12:15pm, does not include the exit route used.

Plan of Correction

Accept () - 07/18/2023)

Moving forward, fire drill reports will include the exit route used. Review was completed of fire drill reports by PCHA for the past 12 months, and no other fire drill reports were missing the exit route. PCHA/designee will educate those who complete the DHS fire drill records to ensure exit route used is noted on the fire drill record and will be completed by July 19th. PCHA/designee will audit the following three fire drills to ensure that the fire route used, is noted on the fire drill report.

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

Implemented () - 08/15/2023)

132d - Evacuation

9. 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

During the fire drill on 10/31/22 at 12:15pm, the home exceeded the maximum safe evacuation time of 15 minutes. The fire drill was completed in 45 minutes.

Plan of Correction

Accept () - 07/18/2023)

Moving forward, fire drill reports will include the evacuation time. Review was completed of fire drill reports by PCHA for the past 12 months, and no other fire drill reports were noted to have the evacuation time in excess of 15 minutes. PCHA/designee will educate those who complete the DHS fire drill records to ensure the evacuation time

132d - Evacuation (continued)

s noted on the fire drill record and will be completed by July 19th. PCHA/designee will audit the following three fire drills to ensure that the fire evacuation time is noted on the fire drill report.

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

Implemented [REDACTED] - 08/15/2023)

132i - Testing Fire Alarm

10. Requirements

2600.

132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the fire drills on 3/8/22 at 5:15am, 6/10/22 at 4:05am, 9/23/22 at 5:05am, 12/5/22 at 3:25am, and 3/13/23 at 2:30am, the fire alarm was not activated.

Plan of Correction

Accept [REDACTED] - 07/25/2023)

Fire Drill was conducted on June 28, 2023 with the fire alarm being initiated during sleeping hours. Moving forward, there will be at least one fire drill during sleeping hours every six months that involved pulling the fire station alarm. PCHA/designee will educate those who complete fire drills that the alarm must be pulled at least once every six months during sleeping hours by July 19th. Residents were also educated on this requirement during resident council on June 28, 2023.

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

Implemented [REDACTED] - 08/15/2023)

141a 1-10 Medical Evaluation Information

11. 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 2 self-administers medication, but their medical evaluation dated [REDACTED] indicates they are not capable of self-administering medication.

Plan of Correction

Accept [REDACTED] - 07/25/2023)

Resident #2 had a DME update completed to reflect the Resident's ability to self-administer medications on [REDACTED]. Other residents who were identified for having medications self administered were reviewed by [REDACTED].

141a 1-10 Medical Evaluation Information (continued)

PCHA/designee to ensure that their DME reflects the ability to self-administer medications completed by July 19th. Education by PCHA/designee, to the licensed Nursing staff on the residents who receive orders to self-administer medications are deemed capable of self-administering medications as per DME by July 19th. Beginning July 20th PCHA/designee will complete random audit of new orders for self-administrated medications weekly for two weeks, to ensure that the resident is deemed capable of self-administering medications per DME. Results and trends will be reported to quality assurance team.

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

Implemented () - 08/15/2023)

183e - Storing Medications

12. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 6/22/23 at 9:55am, there were two loose, white, round pills in the bottom drawer of the medication cart in Personal Care A.

Plan of Correction

Accept () - 07/25/2023)

On June 22, 2023, the two loose white round pills at the bottom of the medication cart in Personal Care A were destroyed. On June 22, 2023, the Nurse Supervisor audited the remainder of the medication carts, and there were no additional concerns of medications not being stored properly. PCHA/designee will educate Nursing Staff of regulation 2600.183e and storing resident medications appropriately by July 19th. Beginning July 20th, PCHA/designee will randomly audit 2 medication carts a week, for two weeks, to ensure that regulation 2600.183e is being maintained. Results and trends will be reported to quality assurance committee.

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

Implemented () - 08/15/2023)

184a - Resident's Meds Labeled

13. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident 3 is prescribed () by mouth once daily. However, the pharmacy label reads 1 tablet by mouth once daily.

Resident 3 is prescribed () 1 tab by mouth twice daily. However, the pharmacy label reads take 1 capsule in the morning and 2 capsules in the evening.

Plan of Correction

Accept () - 07/25/2023)

On June 22, 2023, Resident 3's prescription () pharmacy labels were corrected to reflect

184a - Resident's Meds Labeled (continued)

current order instructions. On June 22, 2023, random audit of four residents whose medications are brought from an outside pharmacy, were reviewed, and there were no noted concerns of labels of not reflecting the current medication order. PCHA/designee will educate Nursing Staff of ensuring pharmacy labels for medications brought from outside pharmacy's, are to reflect current physician orders by July 19th. Beginning July 20th, PCHA/designee will randomly audit 2 resident's medications that are brought from an outside pharmacy, for two weeks, to ensure that the labels match the current physician orders. Results and trends will be reported to quality assurance committee.

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

Implemented [redacted] - 08/15/2023)

185a - Implement Storage Procedures

14. 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

On 6/22/23, Resident 4's glucometer was not calibrated to the correct date. The glucometer was set to 6/23/23.

On 6/17/23 at 4:25pm, Resident 5's blood glucose reading was [redacted]. However, it was documented as [redacted] on the Medication Administration Record.

Plan of Correction

Accept [redacted] - 07/25/2023)

On June 22, 2023, Resident 4's glucometer was calibrated to the correct date. On June 22, 2023, resident 5's documented glucometer reading was struck out and corrected with the glucometer reading of [redacted]. On June 22, 2023, resident glucometers were randomly audited by the Nurse Supervisor, with no additional trends of incorrect dates or documentation. PCHA/designee will educate Nursing Staff on ensuring glucometer dates and documentation are reflected accurately by July 19th . Beginning July 20th, PCHA/designee will complete a random audit of 5 glucometers weekly for two weeks, to ensure dates and documentation are accurately reflected. Results and trends will be reported to the quality assurance committee.

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

Implemented [redacted] - 08/15/2023)

231e - No Objection Statement

15. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident 7 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

231e - No Objection Statement (*continued*)**Plan of Correction**

Accept (█) - 07/25/2023)

Resident 6 and 7 RASP's were updated with the resident and family no objection statement on █. Other memory support resident RASP's were updated with the no objection statement by July 19th. PCHA/designee will complete education with the licensed nursing staff to include the no objection statement when completing RASP's of new admissions to memory support by July 19th. Beginning July 20th, PCHA/designee will randomly audit RASP's of newly admitted residents to memory support to ensure that a no objection statement is present, for two weeks. Results and trends will be reported to the quality assurance team.

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

Implemented (█) - 08/15/2023)

233c - Key-Locking Devices

16. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the exit door to the Secure Dementia Care Unit (SDCU) stairwell #3.

Plan of Correction

Accept (█) - 07/25/2023)

The correct code for the door to stairwell #3 was conspicuously posted on 6/22/2023. Other exit doors were reviewed during survey, and no other doors were identified as not having the correct directions conspicuously posted. PCHA/designee will educate maintenance of ensuring correct directions are conspicuously posted July 19th. Beginning July 20th, PCHA/designee will randomly audit 5 doors a week, for two weeks, to ensure that the correct directions are conspicuously posted. Results and trends will be reported to the quality assurance committee.

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

Implemented (█) - 08/15/2023)