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

November 29, 2023

[redacted], DIRECTOR
MERAKEY PENNSYLVANIA
[redacted]

RE: MERAKEY PENNSYLVANIA
515 DELAWARE AVENUE
BETHLEHEM, PA, 18015
LICENSE/COC#: 22401

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/26/2023 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MERAKEY PENNSYLVANIA* **License #**: *22401* **License Expiration**: *06/11/2024*

Address: *515 DELAWARE AVENUE, BETHLEHEM, PA 18015*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *MERAKEY PENNSYLVANIA*

Address: [redacted]

Certificate(s) of Occupancy

Type: *R-4* **Date**: *04/23/2012* **Issued By**: *Fountain Hill Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *09/26/2023*

Inspection Dates and Department Representative

09/26/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *8*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability**: *2*

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

Inspections / Reviews

09/26/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/28/2023*

11/08/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/20/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/15/2023*

Inspections / Reviews *(continued)*

11/16/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/21/2023*

11/29/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2023*

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

15a Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701 10225.707) and 6 Pa. Code § 15.21 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], Resident #1 was yelling at staff and swinging his/her cane toward staff. During this, Resident #1 hit Resident #2 in the chin with his/her cane as Resident #2 was walking past the exchange. This was not reported to the Department's regional office.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

The Program Administrator completed a DHS incident report and forward it to DHS Regional office on [redacted] Effective [redacted] after an incident occurs an email notification that provides information for the incident will be sent to the Product Leadership Team for review within 12 hours of the incident. After review, the Product Leadership Team will provide next steps to the Administrator for reporting if needed. If a DHS incident report is warranted, one will be completed by the Administrator and forward to the DHS Regional office within the 24-hour requirement. A follow-up email will be sent by the Administrator to the Product Leadership Team with the dates the incident report was completed and when it was received by the Regional Office. If an incident does need to be reported and notification of reporting to DHS has not been received within 24 hours, the Product Leadership Team will follow-up with the Administrator to ensure completion.

Licensee's Proposed Overall Completion Date: *11/13/2023*

Implemented ([redacted] - 11/29/2023)

26a Quality Management Plan

2. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home does not currently have a Quality Management Plan and is not conducting Quality Management meetings.

Plan of Correction ***Accept ([redacted] - 11/16/2023)***

The Program Administrator implemented a change in the PQI Management meeting to Quality Management Plan. Staff were provided with information from the Program Administrator regarding the Quality Management Plan in a team meeting on 10/24/2023. This included a review of all necessary topics - Critical Incidents, Complaints, New Policy/Procedures if any were implemented, Survey Violations and Corrective Action Plans done at that time. This meeting will take place yearly in June. On November 10, 2023, a calendar reminder to review the Quality Management Plan during team meeting for June 2024 has been created for the Program Administrator and Adult Director. Following the Quality Management Plan Team Meeting, the Administrator will audit team meeting logs to ensure all staff have had the training. If a staff member does not attend the Quality Management Plan Team Meeting, a meeting will be scheduled for review within the same month.

Licensee's Proposed Overall Completion Date: *11/13/2023*

Implemented ([redacted] - 11/29/2023)

65e 12 Hours Annual Training

3. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A received only 7.5 hours of annual training in training year 2022.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

On October 24, 2023, the Program Administrator implemented a new training log for staff trainings. Staff were advised of this change on 10/24/2023. Each staff member will have their own sign off log to acknowledge they attended the training, and the duration of time will be documented with their signature. After each training, staff members are responsible for signing their training log. The Administrator will audit each staff member's training log after the monthly meeting to ensure that they signed the training log for that month. The Administrator will continue to monitor the logs to ensure that each staff member receives at least 12 hours of training yearly.

Licensee's Proposed Overall Completion Date: *11/13/2023*

Implemented ([redacted] - 11/29/2023)

65f - Training Topics

4. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff person A did not receive training in care for residents with MH/ID during training year 2022.

Plan of Correction ***Accept [redacted] - 11/08/2023)***

Staff member A was trained in MH/ID on 9/27/2023. A new tracking system will be implemented to track that all required trainings are completed. After the training, each staff member will sign the training log to acknowledge their attendance and completion of the training. After the training and the training logs are complete, the Administrator will review all training logs to ensure all staff present have a completed form.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented ([redacted] - 11/29/2023)

65g - Annual Training Content

5. 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 did not receive training in Emergency Preparedness during training year 2022.

Plan of Correction ***Accept ([redacted] - 11/08/2023)***

Staff member A was trained in Emergency Preparedness on 9/29/2023. After the training, each staff member will sign the training log to acknowledge their attendance and completion of the training. After the training and the training logs are complete, the Administrator will review all training logs to ensure all staff present have a completed form.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented ([redacted] - 11/29/2023)

65g - Annual Training Content *(continued)*

65i - Training Record

6. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Trainings conducted on 11/29/22 "ADLs/IADLs," 12/27/22 "Abuse," and 1/24/23 "Infection Control" did not include the length of the training.

Plan of Correction ***Accept (- 11/08/2023)***

A new training completion log has been implemented which includes the training and length of time of the training. After the training, each staff member will sign the training log to acknowledge their attendance and completion of the training. After the training and the training logs are complete the Administrator will review all training logs to ensure all staff present have a completed form.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented (- 11/29/2023)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On , Resident #3's blood glucose monitor was used to test the blood glucose of Resident #4.

Plan of Correction ***Accept - 11/08/2023)***

A DHS report and Merakey Incident Report were complete don 5/9/2023. Resident #3 received a new blood glucose monitor on 5/9/2023. A review of the DHS Sanitation and Infection Control regulations and Merakey Medication Administration policy will be completed with all staff on 10/24/2023. A cross -walk review of the glucometer and Daily Blood sugar log occurs monthly by the Administrator or Nurse. Any resident with new orders to have blood glucose level checked will be given their own monitor.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented (- 11/29/2023)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The lamp located next to the bed in bedroom B-12 has a burnt-out lightbulb and is not operational.

Plan of Correction ***Accept - 11/08/2023)***

A new light bulb was replaced in bedroom B-12 at time of survey. A Resident Council meeting was held to review

101j7 - Lighting/Operable Lamp (continued)

with the residents to report if any lighting needs replacement/repair in between monthly room checks to staff on 10/19/2023. A review of the expectation for staff to check lighting in accordance with the regulation will be completed on 10/24/2023. A monthly walkthrough form has been implemented which includes staff and residents' signatures. A review of the monthly walkthrough form will be completed by the Administrator monthly. Any issues identified will be followed up immediately in house or through a work order completed with Merakey Facilities Department.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented (- 11/29/2023)

103e - Left Overs

9. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

An unlabeled Chinese food takeout container was found inside the refrigerator located in the dining room.

Plan of Correction ***Accept - 11/08/2023)***

Food was labeled by staff at time of survey. A resident council meeting will be held to review house rules regarding leftover food items in refrigerators on October 19, 2023. Staff will go through the refrigerator weekly to ensure items in the refrigerator are labeled. Any unlabeled items will be thrown away. Any items labeled will be thrown away after 3 days. A weekly refrigerator Check form will be implemented which includes staff signature. A review of the weekly Refrigerator Check form will be completed by the Administrator weekly.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented (- 11/29/2023)

132b - Safety Inspection/Fire Drill

10. 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's most recent fire safety inspection was complete 5/24/23. The previously completed fire safety inspection was conducted 4/27/22, which exceeds the annual timeframes required by this regulation.

Plan of Correction ***Accept (- 11/08/2023)***

The Fire Marshall will be contacted in April to schedule a date for the Inspection and fire drill prior to May 24, 2024. At the completion of the annual fire inspection and fire drill in May 2024, the annual fie inspection and fire drill will be scheduled for May 2025. The annual inspection and supervised fire drill will be scheduled to be completed on the same ay yearly. The due date of the inspection and fire drill for the following year will be added to the calendar of the Administrator and the Adult Director annually.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented (- 11/29/2023)

141a Medical Evaluation

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.

Description of Violation

The Documentation of Medical Evaluation dated [redacted] for Resident #5 does not list the weight of the resident.

Plan of Correction ***Accept ([redacted] - 11/08/2023)***

The physician off of Resident #5 had been contacted to review the missed items on the MA 51 on beginning October 24, 2023. On going prior to leaving a doctor's office a review of the MA 51 form will be completed by staff and any missed items will be reviewed with the physician. Within 24 hours of return from a physician's appointment, the Administrator or nurse will review all required documentation to ensure completion.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented ([redacted] - 11/29/2023)

185a Implement Storage Procedures

12. 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's controlled substance policy includes that the off-going and oncoming nursing staff count the narcotics and then sign the Narcotic Count Sheet. On 9/26/23, Staff Person B signed the Narcotic Count Sheet before the count was completed with the ongoing nursing staff.

Plan of Correction ***Accept ([redacted] - 11/16/2023)***

The Program Administrator reviewed the Medication Policy in regard to the Narcotic Count Policy on 9/27/2023 with staff member B. All staff were sent a memo via email from the Administrator on 10/25/2023 which addressed the Error Correction Procedures to null the signature if one is noted during the during a medication administration and complete the signature once the count is completed. Medication Administration Policies/Procedures were reviewed with all staff on 10/24/2023 by the Program Administrator. Beginning the week of November 13, 2023, an audit of Narcotic Count Log will be done weekly by the Administrator.

Licensee's Proposed Overall Completion Date: *11/13/2023*

Implemented ([redacted] - 11/29/2023)

187d Follow Prescriber's Orders

13. Requirements

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

Description of Violation

On 5/8/23, a blood glucose monitor was used on Resident #4 to check the resident's blood sugar level. Resident #4 does not have an order to receive PRN blood sugar readings.

187d Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept (- 11/08/2023)***

A DHS incident report and Merakey Internal Incident Report were completed on 5/9/2023. Resident #3 received a new blood glucose monitor on 5/9/2023. A review of the DHS Sanitation and Infection Control regulations and Merakey Medication Administration policy will be completed with all staff on 10/24/2023. A crosswalk review of the glucometer and daily Blood Sugar Log occurs monthly by the Administrator or Nurse. A blood glucose monitoring order will be obtained prior obtaining blood glucose levels on any resident. Any resident with new orders to have their blood glucose level checked will be given their own monitor.

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented (- 11/29/2023)

224a - Preadmission Screen Form

14. 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 #5 moved into the home on . The Preadmission Screening Form for the resident was completed on , greater than 30 days prior to admission.

Plan of Correction ***Accept (- 11/16/2023)***

As of November 10, 2023, the Preadmission Screening form will be completed by the Administrator no more than 30 days prior to move in date, If the move in date is later than 30 days after completing the initial Preadmission Screening form, then the Administrator will complete an additional Preadmission Screening form. The required timeframe of 30 days prior to move in for the Preadmission Screening has been added to the Intake Checklist for ensuring the required timeframe is met. The Intake Checklist will be reviewed prior to admission and includes staff signature for completion. The Administrator will do the initial Preadmission screening and will have the Assistant Administrator review prior to admission for compliance.

Licensee's Proposed Overall Completion Date: *11/13/2023*

Implemented (- 11/29/2023)

252 - Record Content

15. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

The resident record for Resident #6 does not contain information regarding any identifying marks.

Repeat violation: 5/3/22

Plan of Correction ***Accept (- 11/16/2023)***

The Face Sheet for resident #6 was updated on September 26, 2023, at time of survey to reflect no identifying marks. An audit of each resident's face sheet was completed, and no issues were identified. On October 25, 2023, the Intake Checklist has been updated to include ensuring all areas of the Face Sheet are completed. Beginning October25,

252 Record Content (continued)

2023, Intake Checklists will be reviewed by the Administrator prior to admission to ensure completion.

Licensee's Proposed Overall Completion Date: 11/13/2023

Implemented ([redacted] - 11/29/2023)