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

February 21, 2024

[redacted], ADMINISTRATOR
PHOEBE BERKS HEALTH CARE CENTER, INC.
[redacted]

RE: PHOEBE BERKS VILLAGE
1 READING DRIVE
WERNERSVILLE, PA, 19565
LICENSE/COC#: 20536

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/27/2023, 09/28/2023, 10/05/2023 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: *PHOEBE BERKS VILLAGE* **License #**: *20536* **License Expiration**: *07/30/2024*

Address: *1 READING DRIVE, WERNERSVILLE, PA 19565*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *PHOEBE BERKS HEALTH CARE CENTER, INC.*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/04/1994* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *128* **Waking Staff**: *96*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/05/2023*

Inspection Dates and Department Representative

09/27/2023 - On-Site: [redacted]
09/28/2023 - On-Site: [redacted]
10/05/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *85*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Gardens* **Capacity**: *37* **Residents Served**: *31*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *85*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *43* **Have Physical Disability**: *0*

Inspections / Reviews

09/27/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/05/2023*

Inspections / Reviews *(continued)*

11/14/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/22/2023*

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

11/28/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/22/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/03/2023*

02/21/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/22/2023*

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The computer on the Medication Cart located in the Secure Dementia Care Unit, located in the hallway outside the dining area was left unlocked and unattended. The Licensing Representative moved the mouse and resident information appeared on the screen. The staff utilizing the computer was out of the line of sight of the medication cart. The unlocked computer contained confidential information of the residents.

Plan of Correction ***Accept ([redacted] - 11/28/2023)***

All staff who work in the personal care home setting who have access to resident's records are responsible to keep them confidential. Nurse supervisor made the computer private immediately on 9/27/23 and educated the nurse assigned to that cart. Education to all staff on privacy and HIPPA by administrator or designee was reviewed in October monthly staffing meetings on 10/25/23 and 10/26/23. Education on Privacy and HIPPA will be conducted by administrator or designee to all staff who did not attend October staff meeting by 12/18/23. Staff development to assign annual HIPPA/privacy training to be completed by all staff by 12/31/23. Administrator and or designee will complete random monthly audits of all medication carts being in privacy setting when unattended to ensure compliance starting on 12/18/23. Results of the audits will be reviewed at quarterly QA meeting by administrator or designee to ensure ongoing compliance. If during audits a computer is discovered not to be left in a privacy setting it will be immediately placed into a privacy setting by administrator or designee who is completing the audit . The staff person who is responsible for the computer will be notified after computer set to private and re-education provided that same day.

Proposed Overall Completion Date: 12/18/2023

Directed: Administrator will monitor for ongoing compliance. [redacted]

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 02/21/2024)

91 - Telephone Numbers

2. Requirements

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

The phone at the entrance to the Personal Care Side of the building did not have the required emergency phone numbers posted.

Plan of Correction ***Accept ([redacted] - 11/28/2023)***

Missing numbers were posted by the Nurse Manager on 9/29/23 . During October staff meetings on 10/25/23 and

91 Telephone Numbers (continued)

10/26/23 education of this violation was completed to all staff in attendance. Additional, trainings will be conducted to include staff who work directly in resident's room who missed the meetings by administrator or designee by 12/18/23 to be observant when in residents room that if phone numbers are to be noted to be missing to inform administrator or designee so can be replaced within 72 hours of notification. Administrator or designee will complete monthly random audits of phones with outside lines to ensure compliance and then be reviewed at quarterly QA meeting by administrator or designee. Audits will be implemented by no later than 12/18/23. Any missing emergency phone numbers discovered from the telephones that have outside lines will be posted within 72 hours by administrator or designee. Reeducation will be given to the staff persons who work directly in the room/areas where phone number were missing within 72 hours of incident.

Proposed Overall Completion Date: 12/18/2023

Directed: Any missing emergency phone numbers discovered from the telephones that have outside lines will be posted immediately by administrator or designee. Administrator will monitor for ongoing compliance. [redacted]

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented ([redacted] - 02/21/2024)

101j7 - Lighting/Operable Lamp

3. 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

In Room 401, both residents sleep in a recliner. The recliner inside the door does not have a light source that can be turned on from the recliner.

Repeat Violation 6/28/2022.

Plan of Correction ***Accept [redacted] - 11/28/2023)***

On 9/29/23 a light source was placed in area that it was missing from by Nurse Manager. Staff education to be provided to all staff by administrator or designee, education was provided during October staff meetings on 10/25/23 and 10/26/23. Additional trainings will be conducted 12/18/23 to include staff who missed the meetings by administrator or designee. Random monthly audits will be conducted, additionally with new admissions, and or furniture moves by administrator and or designee to be implemented by 12/18/23. These audits will then be reviewed at our quarterly QA meeting by administrator or designee. When audits find light sources missing, they will be put into place within 72 hours of discovery by administrator or designee and re education will be provided to staff assigned to room(s) where light source was missing within 72 hours of the finding.

Proposed Overall Completion Date: 12/18/2023

Directed: When audits find light sources missing, they will be put into place immediately upon discovery by administrator or designee. Administrator will monitor for ongoing compliance. [redacted]

Licensee's Proposed Overall Completion Date: *12/18/2023*

101j7 Lighting/Operable Lamp *(continued)*

Implemented (- 02/21/2024)

103e Left Overs

4. 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

The 2nd floor freezer in the kitchenette had unlabeled, unidentifiable food stored in it.

Plan of Correction ***Accept - 11/28/2023)***

Mentioned food items were immediately discarded by dietary staff on 9/27/23. Staff education to be provided to all staff by administrator or designee, education was provided during October staff meetings on 10/25/23 and 10/26/23, and additional trainings will be conducted to include staff who missed the meetings by administrator or designee by no later than 12/18/23 to include all staff (Nurse, med-tech, RCP, and dietary staff) who utilize refrigerators and or handle food on behalf of the resident. Weekly audits to be conducted by direct care staff who work on 11-7 with instructions to remove items if found not to be in compliance during audit and inform the administrator or designee of non-compliance so re-education can be completed by administrator and or designee to staff working in that neighborhood. Audits will be implemented by 12/18/23. Audits with finding will be reviewed at quarterly QA meeting by administrator or designee.

Proposed Overall Completion Date: 12/18/2023

Directed: Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented - 02/21/2024)

103f Refrigerator/Freezer Temps

5. 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

The refrigerator in the Personal Care Home breakroom, to the left of room 80 had a thermometer reading 48 degrees.

Plan of Correction ***Accept - 11/28/2023)***

Thermometers were replaced in all refrigerators and freezers in all 3 kitchenettes and each read at safe temperatures per 103.f regulation on 9/28/23. When temperatures were later checked by administrator on 9/28/23 all had safe readings in harmony with the regulation. In subsequent audit performed by dietary manager on 10/23/23 it was discovered the refrigerator on the second floor kitchenette was reading above 40 degrees and was replaced the same day. Staff education to be provided to all staff by administrator or designee, education was provided during October staff meetings on 10/25/23 and 10/26/23, and additional trainings will be conducted to include staff who missed the meetings by administrator or designee by no later than 12/18/23. Updated daily audits will to be started by no later than 12/18/23 to be conducted by direct care staff on 11-7 with instruction to inform administrator or designee if temperatures are outside of appropriate parameters per regulation so can be addressed the following morning with

103f - Refrigerator/Freezer Temps (continued)

first replacing thermometer and if still reading outside of the safe temperature to initiate replacement process with environmental services to replace the refrigerator unit. The refrigerator will be removed same day if environmental services deems the unit unable to be fixed. The logs will be additionally reviewed weekly by administrator or designee as a second check. If during second check an unsafe temperature is discovered on the log that was not reported it will be addressed the same day by administrator or designee and re-education will be provided to the direct care staff who complete the audits. Administrator and or designee will review logs at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 02/21/2024)

125a - Combustible Storage

6. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

In the Secure Dementia Care Unit laundry room, there was a pillowcase on the dryer vent, posing a fire hazard.

Plan of Correction ***Accept [redacted] - 11/28/2023)***

Flammable material was immediately removed by administrator on 9/27/23. Staff education to be provided to all staff by administrator or designee, education was provided during October staff meetings on 10/25/23 and 10/26/23. Additional trainings will be conducted to include staff who missed the meetings by administrator or designee by no later than 12/18/23. Daily audits to be conducted by direct care staff with instruction to first remove safety hazard if possible and then to inform administrator or designee if hazard was found and action taken. If hazard was not able to be immediately moved by staff. Administrator and or designee will contact environmental within 24-hours of notification of the hazard. The laundry room will be temporarily closed the same day by the direct care staff who conducted the audit until environmental services can inspect and clear the laundry room of the hazard and then will let administrator and or designee know it may reopen. The logs will be additionally reviewed weekly by administrator or designee as a second check. If during second check an unsafe item is noted on the log that was not reported it will be addressed the same day by administrator or designee and re-education will be provided to the direct care staff who complete the audits. Administrator and or designee will review logs at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 02/21/2024)

132a - Monthly Fire Drill

7. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The facility is running fire drills for the Secure Dementia Care Unit and the Personal Care Home separately although they are housed in the same building. Ancillary staff member A and the homes Administrator both stated they are conducted on the same day at different times. In doing this they are announcing to the staff there will be a fire drill on the other side that day.

132a - Monthly Fire Drill (continued)

There were no fire drills conducted 5/2023, 6/2023, or 7/2023.

Plan of Correction ***Accept [redacted] - 11/28/2023)***

On, October 27th 2023 unannounced fire drill was conducted and included the Personal Care Home and Secure Dementia Care Unit simultaneously to which both were evacuated to fire safe areas. All monthly unannounced fire drills will be ran by a member of environmental services as appointed by their department director. A Fire Safety and Compliance team was formed with administrator, executive director, environmental services director, safety officer, activity director, and a member of our direct care staff and the first meeting was held on November 1, 2023 to discuss obstacles and what the regulations are to gain a better understanding and be able to have more staff who can train. Monthly schedule will be set by administrator or designee and coordinated with director of environmental services to conduct the unannounced drills to ensure they are done monthly. Staff education to be provided to all staff by administrator or designee, education was provided during October staff meetings on 10/25/23 and 10/26/23. Additional trainings will be conducted to include staff who missed the meetings by administrator or designee by no later than 12/18/23. Within the last 7-days of the month the administrator and or designee will review the fire drill logs to ensure once was held that month, if there was not will coordinate with the director of environmental services to ensure it is done unannounced by month's end. Results will be reviewed at quarterly QA meeting by administrator and or designee.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented ([redacted] - 02/21/2024)

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

10/10/22 Fire Drill Log does not list if the fire alarm or smoke detector was operative. N/A is indicated on the log.

On 12/16/23, 1/5/23, 2/8/23, 3/12/23, and 4/11/23, the Fire Drill Log does not indicate if any problems were encountered during the fire drill.

11/28/2022 the Fire Drill Log does not list the total number of staff participating in the drill or the total number of residents evacuated.

12/19/22 The fire drill log does not list the total number of residents evacuated.

1/5/2023 the Fire Drill Log does not list the total number of residents evacuated or the exit route used to evacuate.

3/12/2023 the Fire Drill Log does not list the exit route used to evacuate.

132c - Fire Drill Records *(continued)*

Plan of Correction ***Accept (- 11/28/2023)***

Environmental services director has been educated on appropriate form to use and filling it out in it's entirety to include all information listed in 132.c at Fire Safety Compliance team meeting on 11/1/23. Environmental staff person who is appointed by their department director to run the monthly unannounced drill is responsible to fill out the form in it's entirety. Administrator or designee will audit forms used after each drill within 24 hours thereafter for form completion with starting this process by no later than 12/18/23. If upon audit information is found to be missing , re-education will be provided to the environmental services staff who conducted the drill. An subsequent unannounced drill will be repeated that same month to ensure compliance and understanding of the process. Both forms and audits will be reviewed at quarterly QA meeting by administrator or designee.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented (- 02/21/2024)

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

The letter from the fire safety expert indicating the homes safe evacuation time based on the physical construction of the home is 8 minutes. The fire drill conducted on 1/5/23 took 10 minutes for evacuation. The fire drill conducted on 2/8/23 took 8 minutes for evacuation. The fire drill conducted on 4/22/23 took 8 minutes to evacuate.

Plan of Correction ***Accept - 11/28/2023)***

Unannounced fire drill was conducted on 10/27/23 and all residents in personal care and memory support were evacuated in the assigned time of less than 8 minutes. Staff education to be provided to all staff on allowed times for evacuation as assigned to us by fire safety expert by administrator or designee, education was provided during October staff meetings on 10/25/23 and 10/26/23, and additional trainings will be conducted to include staff who missed the meetings by administrator or designee by no later than 12/18/23. Appointed environmental services staff person who is conducting the drill will inform the administrator and or designee within 72-hours post the drill if the evacuation process took greater than the 8 minutes allotted. Administrator or designee will review form after each drill within 72-hours as a double check to ensure assigned times are being followed. If the evacuation is greater then the 8 minutes we have been allotted, a repeat unannounced drill will be conducted that month that is ran by the appointed environmental services staff person. If the drill again, takes greater than 8 minutes the administrator or designee will reach out to the fire safety expert to request to get retimes and or provide education for more efficient evacuation. This process will be implemented by no later than 12/18/23.

Proposed Overall Completion Date: 12/18/2023

Directed: If the drill again, takes greater than 8 minutes the administrator or designee will reach out to the fire safety expert to provide education for more efficient evacuation. The Administrator will assess the residents ongoing changing care needs and staffing needs to meet the allotted safe evacuation time frames.

Licensee's Proposed Overall Completion Date: *12/18/2023*

132d Evacuation *(continued)*

Implemented [redacted] - 02/21/2024)

132h Designated Meeting Place

10. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire safe area during each fire drill.

Description of Violation

The Village Cottages (Personal Care Home) and the Village Gardens (Secure Dementia Care Unit) are conducting fire drills separately, although they are in the same building. They are being done on the same day at different times. In doing this, the facility is not evacuating all residents during a fire drill.

The fire drill conducted on 6/15/22 8 of 56 residents were evacuated.

The fire drill conducted on 2/8/23 16 of 56 residents were evacuated.

The fire drill conducted on 9/22/23 zero residents were evacuated.

Plan of Correction ***Directed [redacted] - 11/28/2023)***

Administrator and or designee to review with all staff the locations of fire safe areas in both Village Commons and Gardens, education was provided during October staffing meetings on 10/25/23 and 10/26/23 and additional trainings will be provided for those who were not in attendance by administrator and or designee by no later than 12/18/23. Environmental services staff person who conducted the drill will inform the administrator and or designee within 72-hours after the drill to inform them of any issues with the evacuation process. As a double check within 72 hours after each drill administrator and or designee will audit fire drill records to ensure all residents were evacuated to fire safe areas. If upon reviewing records and or being informed by the environmental services staff person conducting the drill it was noted particular areas and or floors did not evacuate or had any difficulty, re-education will be provided to the persons/areas where the issues occurred and a repeat unannounced drill will be held that month. These audits with findings will reviewed at the quarterly QA meetings by the administrator and or designee. This process will be started by no later than 12/18/23.

Proposed Overall Completion Date: 12/18/2023

Directed: Environmental services staff person who conducted the drill will inform the administrator and or designee immediately after the drill to inform them of any issues with the evacuation process. The Administrator will monitor for ongoing compliance.[redacted]

Directed Completion Date: *12/18/2023*

Implemented [redacted] - 02/21/2024)

181c Self administration Assessment

11. Requirements

181c - Self-administration Assessment *(continued)*

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident # 1 currently self-administers their prescribed [redacted]. Per Resident # 1 most recent medical evaluation, dated [redacted] the resident is not able to self-administer medications.

Plan of Correction ***Accept [redacted] - 11/28/2023)***

Nurses, administrator, and or designee are responsible to ensure DMEs are completed in their entirety and accurate. Resident #1 was re-evaluated by his PCP for his ability to self-administer his nitroglycerin and deemed capable of doing so as requested by the nurse manager when made aware of this error. Resident #1 DME was updated with this addendum on [redacted]. Education on this violation was provided to staff at October 25 and 26, 2023 staff meetings. Additional, training will be provided to staff who did attend will be conducted by administrator and or designee by no later than 12/18/23. Audits of DME will be conducted by administer and or designee upon admission, readmission, quarterly, and or significant changes to review for accuracy and will be implemented by no later than 12/18/23. These audits will then be reviewed at the quarterly QA meeting by administrator and or designee.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 02/21/2024)

183d - Prescription Current

12. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident # 2 had [redacted] in the home's medication cart. The resident is not currently prescribed [redacted] per the resident's medication administration record (MAR).

Plan of Correction ***Accept [redacted] - 11/28/2023)***

Nurse, med-tech, and or administrator/designee are responsible to make sure that all medications on the carts must have current orders. Upon, discovery of missing order of the [redacted] of which was on the cart but not on the MAR. The nurse supervisor on shift reached out the same day (9/28/23) to the PCP who gave the order for the medication and was then reflected on the MAR. Education to be provided to all staff and was reviewed on October 25th and 25, 2003 staff meetings. Additional, trainings will be held by no later than 12/18/23 to include staff who missed the October meeting to be educated by administrator and or designee. Monthly audits will be conducted by administrator and or designee to ensure all medications in the cart match the MAR to be implemented by no later than 12/18/23. If medications are found that do not have a current order they will be immediately pulled from the cart on the same day they are discovered by who discovered them either nurse, med-tech, and or administrator/designee. The nurse assigned to that unit will then reach out to the resident's PCP will be to see if they would like to have an order in place for the medication. If not the resident family/representative will be contacted to see if they would like to pick up the medication and or have us destroy it also on the same day of discovery. In incidents where medications are discovered without orders subsequent re-education will occur to the staff who dispensed medications from that cart of discovery going back to previous date of audit. Audits will be reviewed at the quarterly QA meeting by administrator or designee. This process will be implemented by no later than 12/18/23.

183d - Prescription Current *(continued)*

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented (- 02/21/2024)

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:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident # 2 is prescribed [redacted] The directions on the medication label state to administer the medication twice daily. The resident's medication administration record (MAR) states that the medication is to be administered as needed. It was determined that the MAR is correct.

Plan of Correction ***Accept - 11/28/2023)***

Nurse, med-tech, and or administrator/designee are responsible to make sure that all medications on the carts labels match what is on the MAR for the resident. Staff education was provided on this citation at October 25 and 26, 2023 staff meetings by administrator. Additional, trainings/education will be provided to staff who did not attend those meetings by no later than 12/18/23. Upon, discovery of the label not matching the MAR the nurse on shift on 9/28/23 reached out to PCP for clarification and PCP stated it was to be as needed as indicated on the MAR and label was immediately updated to match the MAR on 9/28/23. If medications are found that the label and MAR do not match, they will be immediately pulled from the cart on the same day they are discovered by who discovered them either nurse, med-tech, and or administrator/designee. The nurse assigned to that unit will then reach out to the resident's PCP to get clarification of the order and nurse will ensure that either pharmacy updates the MAR or label as indicated by the physician's order. In incidents where medications are discovered that the labels do not match the MARS subsequent re-education will occur to the staff who dispensed medications from that cart of discovery going back to previous date of audit. Audits will be reviewed at the quarterly QA meeting by administrator or designee. This process will be implemented by no later than 12/18/23.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented - 02/21/2024)

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

The home's controlled substance policy states that the off-going and oncoming nursing staff will count the narcotics and sign the Med Cart Shift Change record when the count has been completed. On 9/28/23, Staff Person C signed the Med Cart Shift Change record before counting the narcotics with the oncoming nursing staff.
Staff Person C administered Resident # 3 [redacted] at [redacted]. Staff Person C did not document that this controlled substance was administered on the home's Controlled Drug Receipt Record/Disposition sheet.

185a Implement Storage Procedures *(continued)*

Plan of Correction ***Accept [redacted] - 11/28/2023)***

Narcotic count took place with staff person C and oncoming shift nurse and no discrepancies were discovered on 9/28/23 the date incident occurred. Staff person C received education on 10/2/23 in regards to the inappropriate handling and documentation of narcotics. On 10/25/23 and 10/26/23 during monthly nurse's and med tech meeting education provided to all staff in attendance for appropriate process of narcotics in harmony with 185.a. Additional, training will be provided by no later than 12/18/23 for all nurses and med techs who did not attend October staff meetings. Completed narcotic sheets are given to the administrator and or designee and will be reviewed for any incomplete or suspicious entries when handed in within 72 hours of receiving. Monthly random audits will be conducted by administrator and or designee to ensure compliance of appropriate handling of narcotics by nurses and med techs. Any incomplete or inappropriate discoveries with audits or narcotic sheet reviews will result in same day re education to all parties involved by administrator and or designee. Audits and narcotic sheets will be reviewed at quarterly QA meeting by administrator and or designee. This process will be implemented by no later than 12/18/23.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 02/21/2024)

221c - Post Activity Calendar

15. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The facility did not have an Activities Calendar posted. The administrator stated the activities calendar are distributed as flyers to residents.

Plan of Correction ***Accept [redacted] - 11/28/2023)***

Activity calendars were posted on the second and first floor but was missing from the ground floor outside of the activity room. Education was provided to activity staff on 9/27/23 and additionally reviewed with nursing during October 25th and 26th staff meetings. The responsibility to make sure the calendars get posted is of the activity coordinator who oversees the activity department and in her absence her appointed designee. Weekly audits are to be completed by community life staff assigned to the task by their department coordinator to ensure calendars are on each floor of the personal care home. During audits if missing calendars are found they are to be replaced by the community life staff person conducting the audit and are to inform the Coordinator. Coordinator then will provide re education to the staff who work on the neighborhood. The coordinator will review these audits on a monthly basis and will review the audits with findings at the quarterly QA meeting. This process will be implemented by no later than 12/18/23.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 02/21/2024)

224a - Preadmission Screen Form

16. 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.

224a - Preadmission Screen Form *(continued)*

Description of Violation

Resident #4's Preadmission Screening dated 5/3/23 is missing "Reason for Leaving Current Residence."

Plan of Correction ***Accept (- 11/28/2023)***

Education provided to staff who complete preadmission screenings at nurse's meeting on 10/25/23 by administrator. Additional, training will be provided to staff who may be assigned to fill out the forms whom were not present by no later than 12/18/23 by the administrator. Resident #4 as currently assessed needs are being met at the personal care home. All admissions the preadmission screening form will be audited within 7-days prior to admission to the facility to ensure compliance by administrator and or designee. These audits will be reviewed at quarterly QA meeting by the administrator and or designee. This process will be implemented by no later than 12/18/23.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented (- 02/21/2024)

231g - Non-Dementia Admission

17. Requirements

2600.
231.g.3. The individual shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the secured dementia care unit.

Description of Violation

Resident #2 date of admission does not have a diagnosis of but chooses to live on the secured dementia care unit (SDCU). The resident states he/she does not have the code to leave the SCDU and always asked the staff to get through the doors.

Plan of Correction ***Accept - 11/28/2023)***

On 10/5/23 code was provided to resident #2 but upon practicing with the resident demonstrated the inability to be able to operate the keypad to get in/out. RASP was updated to reflect the above on . Staff education was provided in October staffing meetings on 10/25/23 and 10/26/23 for residents who reside in the memory support currently and in the future who does not have a diagnosis of dementia may have the code. Additional, training will take place for memory support staff who were not in attendance in October by no later than 12/18/23. Effective 9/28/23 the administrator and or designee will offer the code to any person admitted to the memory support unit whom does not have a diagnosis of dementia and make sure it is in their resident support plan with their personal preference and or ability to use it. Since, 9/28/23 we have not received an admission that falls into that criteria. Residents living in our memory care without the diagnosis of dementia will be reviewed at our quarterly QA meetings by the administrator and or designee to ensure we are reviewing and meeting this regulation.

Proposed Overall Completion Date: 12/18/2023

Directed: Staff will assist Resident #2 with exiting the unit as necessary. Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented - 02/21/2024)

233c - Key-Locking Devices

18. Requirements

233c - Key-Locking Devices *(continued)*

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 Exit of the fenced in courtyard in the Secure Dementia Care Unit is locked with a key locking device. The keypad does not have a code posted to operate the key locking device.

Plan of Correction ***Accept [redacted] - 11/28/2023)***

Upon, discovery of the missing posted code from the fenced in courtyard it was posted the same day by nurse manager on 9/27/23. Education was provided to memory support staff at the 10/25/23 and 10/26/23 staff meetings. Additional, training will be conducted to include the memory support staff who were not in attendance by no later than 12/1823 by the administrator and or designee. Weekly audits of the entrance/exits in memory support will be conducted to ensure the codes are posted at each exit and will be conducted by a member of direct care staff as assigned by the administrator and or designee. Direct care staff will inform the administrator and or designee of any codes missing the day it is discovered so it may be replaced within 72-hours of finding. These audits will be turned in to the administrator and or designee on a monthly basis as a second check. For any instances where exit doors are discovered to be missing the code posted re-education will occur to the staff assigned to that neighborhood in memory support. Completed audits with findings will be reviewed by administrator and or designee at quarterly QA meeting with starting this process by no later than 12/18/23.

Proposed Overall Completion Date: 12/18/2023

Directed: Direct care staff will inform the administrator and or designee of any codes missing the day it is discovered so it may be replaced immediately after finding. Administrator will monitor for ongoing compliance.[redacted]

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented ([redacted] - 02/21/2024)