

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

January 26, 2024

[REDACTED]
DISCOVERY READING LEASING LLC
[REDACTED] 100
[REDACTED]

RE: RITTENHOUSE VILLAGE AT
MUHLENBERG
2900 LAWN TERRACE
READING, PA, 19605
LICENSE/COC#: 22802

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/13/2023 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: RITTENHOUSE VILLAGE AT MUHLENBERG License #: 22802 License Expiration: 05/01/2024
 Address: 2900 LAWN TERRACE, READING, PA 19605
 County: BERKS Region: NORTHEAST

Administrator

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

Legal Entity

Name: DISCOVERY READING LEASING LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 11/17/2009 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 88 Waking Staff: 66

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Incident Exit Conference Date: 12/13/2023

Inspection Dates and Department Representative

12/13/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 104 Residents Served: 84

Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:

Hospice
 Current Residents: 4

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 84
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 1
 Have Mobility Need: 4 Have Physical Disability: 0

Inspections / Reviews

12/13/2023 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/28/2023

12/28/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 01/25/2024
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 01/03/2024

Inspections / Reviews *(continued)*

01/26/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/25/2024

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 [redacted] had a verbal altercation with staff. Resident [redacted] called police from the front desk phone. When police arrived staff person A stated they heard resident [redacted] telling police that they were hit by staff during the verbal altercation. According to administrator B, this was not reported as suspected abuse as required by staff person A.

Plan of Correction

Accept [redacted] - 12/28/2023)

- Resident [redacted] had a change of mental status on [redacted].
- Resident [redacted] was arguing with night shift staff and attempting to exit the community.
- Night shift staff contacted 911 and attempted to prevent Resident [redacted] from exiting the community.
- Day shift staff arrived for their shift and assisted with Resident [redacted].
- Ambulance and police arrived to assist.
- Resident [redacted] taken to the hospital for evaluation and treatment for change in mental status.
- Staff reported the incident to Director of Health and Wellness.
- Staff did not report to the Director of Health and Wellness or the Executive Director that they heard Resident [redacted] state that they were hit by staff during the incident.
- Protective Services Manager from the Berks County Office of Aging arrived at the community on [redacted] regarding allegations made by Resident [redacted] while at the hospital.
- Protective Services Manager met with Resident [redacted] and staff that were present during the incident.
- Executive Director investigated the allegations stated by Protective Services Manager and submitted Reportable Incident for to DHS and did not find the allegations to be true.
- Protective Services Manager did not find the allegations to be true and closed the incident.
- Executive Director will educate all staff on [redacted] to immediately notify the Executive Director if a resident complains any form of abuse or if abuse is suspected.
- Executive Director will monitor for compliance by educating staff and reporting any complaints of abuse or incidents to DHS within 24 hours.

Licensee's Proposed Overall Completion Date: 01/18/2024

Implemented [redacted] - 01/26/2024)

227d - Support Plan Medical/Dental

2. 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

Resident [redacted] has a history of [redacted] and has voiced a lack of desire to live to staff in the home. Resident [redacted] [redacted] are documented in office visits with psychiatric counselors. The support plan dated [redacted] was not

227d - Support Plan Medical/Dental (continued)

updated regarding resident [REDACTED] suicidal ideations. Resident [REDACTED] also has a wander guard in place. The support plan does not indicate the reason for the need to use a wander guard for resident [REDACTED]

Plan of Correction**Accepted [REDACTED] - 12/28/2023)**

- Resident [REDACTED] has expressed the desire to live at previous apartment and the lack of desire to live at the community.
- Resident [REDACTED] is no longer capable of living independently due to mental health concerns and the inability to properly care for themselves.
- Resident [REDACTED] are documented in office notes with psychiatric counselors but has not expressed to staff at the community.
- A wander guard was placed on Resident [REDACTED] due to the lack of desire to live at the community and continually expressing the desire to go back to previous apartment.
- Support plan dated [REDACTED] was updated on [REDACTED] by the Executive Director to indicate that Resident [REDACTED] has a wander guard in place and to monitor for exit seeking behaviors.
- Support plan dated [REDACTED] was updated on [REDACTED] by the Executive Director to indicate that Resident [REDACTED] has occasional [REDACTED] due to the desire to live independently and the lack of desire to live at the community. If Resident [REDACTED] is tearful, exit seeking and/or stating comments of not wishing to be at the community staff will conduct 1 hour checks and report this behavior to the Director of Health and Wellness.
- Executive Director will educate the Director of Health and Wellness and Nursing Supervisor were re-educated on [REDACTED] on updating resident RASP to indicate residents that have wander guards, exit seeking behaviors and any mental health concerns
- Executive Director will monitor for compliance by educating staff and monitoring resident support plans.

Licensee's Proposed Overall Completion Date: 12/28/2023

Implemented [REDACTED] - 01/26/2024)