

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

June 11, 2024

[REDACTED], AUTHORIZE OFFICER
READING AID II OPCO LLC
[REDACTED]

RE: MAIDENCREEK PLACE
105 DRIES ROAD
READING, PA, 19605
LICENSE/COC#: 22658

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/31/2024 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: MAIDENCREEK PLACE License #: 22658 License Expiration: 05/15/2024
 Address: 105 DRIES ROAD, READING, PA 19605
 County: BERKS Region: NORTHEAST

Administrator

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

Legal Entity

Name: READING AID II OPCO LLC
 Address: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 10/01/2004 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 62 Waking Staff: 47

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint, Incident Exit Conference Date: 01/31/2024

Inspection Dates and Department Representative

01/31/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 75 Residents Served: 41
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 3
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 41
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 21 Have Physical Disability: 0

Inspections / Reviews

01/31/2024 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/01/2024

06/11/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/08/2024
 Reviewer: [REDACTED] Follow-Up Type: Bypass Document Submission

Inspections / Reviews *(continued)*

06/11/2024 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/11/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED] at [REDACTED] and at [REDACTED] resident #9 was administered the incorrect dosage of medication. The resident was administered [REDACTED] of [REDACTED] in place of [REDACTED] of [REDACTED] that was prescribed by the physician. The concentration of the medication was adjusted from [REDACTED] for the new bottle of [REDACTED] that was opened on [REDACTED]. The error was discovered by staff person B at the home after the second dosage was administered at [REDACTED]. The resident became increasingly lethargic. Resident #9 was found unresponsive on [REDACTED] and was pronounced dead.

Plan of Correction

Accept [REDACTED] - 04/08/2024)

Request to Withdraw violation due to there was no intent to do harm.

Upon identification of a medication error, the nursing staff at the facility promptly collaborated with Hospice services to procure physician orders for the potential administration of [REDACTED], a medication capable of reversing overdose effects. Nevertheless, it was noted that the resident was under hospice care and in the terminal stages of life. In accordance with the wishes of the Power of Attorney (POA), the decision was made to abstain from administering Narcan.

The Med Error was identified and self-reported by Community on [REDACTED]. (Exhibit 1)

In-House investigation was completed and determined the event to be Unfounded as an act of neglect by the Med Tech.

Coroner's Report states Cause of Death as [REDACTED] and [REDACTED] (Exhibit 2)

On 2/21/24, Regional Specialist educated Resident Wellness Director (RWD) that only pre-filled syringes will be accepted by the Community when liquid comfort meds are prescribed.

(Exhibit 3)

On 1/26/24, Regional Specialist notified Hospice provider that only pre-filled syringes will be accepted by the Community when liquid comfort meds are prescribed. This communication is reflected in the re-order of medication as pre-filled syringes. (Exhibit 4)

RWD will monitor Physician Order Statements (POS) and EMAR Medication Dashboard to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 04/09/2024

Implemented [REDACTED] - 06/11/2024)

60a - Staff/Support Plan

2. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home currently has 21 immobile residents. 12 of these residents require assistance of 2 staff to transfer into their wheelchair, 3 of whom require a staff person to propel their wheelchair to evacuate to the outside of the building. 6 of

60a Staff/Support Plan (continued)

these residents require assistance of 1 staff to transfer into their wheelchair, 2 of whom require a staff person to propel their wheelchair to evacuate to the outside of the building. 2 residents require constant cueing to be able to evacuate safely. 1 resident cannot hear the fire alarms and is not effectively alerted by the flashers in their bedroom and staff must wake this resident and alert them to evacuate. The home does not have any internal fire safe areas.

On [REDACTED], the home only had 2 staff scheduled on 3rd shift. Other days, the home regularly schedules 3 staff persons on 3rd shift. The home does not have adequate staff scheduled on 3rd shift to meet the needs of the residents in the event of an emergency.

REPEAT VIOLATION 5/2/23 et al.

Plan of Correction

Accept [REDACTED] - 04/08/2024)

Request to Withdraw violation due to at the time of inspection, the Community had 41 residents with 13 residents assessed as immobile Equating a minimum of 13.5 staff hours per Regulation.

The breakdown in the 13 immobile residents is as follows:

- Immobility as it relates to resident cognitive status: 6 of the 13 residents can follow simple instructions and physically ambulate or self propel toward the evacuation route.
- 5 of the remaining 7 residents are physically challenged requiring minimal to full assistance with mobility.
- 5 of the 7 require 2 people to assist to transfer into wheelchair.
- 4 of the 7 once transferred require physical assistance or staff member assistance with w/c transportation.
- 3 of the 7 can self propel once transferred.

The community can verify this information through RASP and HHC/Therapy weekly documented resident status and service needs.

The community is also able to verify the Master Schedule in effect that includes an 11p 7a staffing pattern of 3 aides and 1 med tech with on average 4 team members on shift each night. (Exhibit 5)

It is considered best practice by the Community to maintain a staffing of 4 staff members on 3rd shift which equates to 30 staff hours on this shift 1 Med Tech and 3 Care Aides (Exhibit 5)

On 1/30/24, 4 staff members were scheduled. 2 Care Aides did call off and the 2 full shifts were unsuccessfully attempted to be covered with alternative staff prior to start of the shift.

Partial Shift Hours were able to be covered resulting in a total of 28 staff hours on shift: (Exhibit 6)

11:30pm 3:30am, The Regional Specialist (an LPN) reported to Community to provide care services.

At 1:15am, a Care Aide reported to Community to help cover call out.

At 3:30am, an additional 1st shift Care Aide reported early to Community to help with care services.

At 4:30am, an additional 1st shift Care Aide reported early to Community to help with care services.

RWD or designee will monitor staff schedule and attendance to ensure ongoing compliance

Licensee's Proposed Overall Completion Date: 04/09/2024

Implemented [REDACTED] - 06/11/2024)

130e - Hearing Impairment

3. Requirements

2600.

130e - Hearing Impairment (continued)

130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #1 has flashers in room that are activated when the fire alarms are activated. Per staff interviews, Resident #1 is not always alerted by flashers and staff need to alert the resident that the fire alarms have been activated.

Plan of Correction

Accept - 04/08/2024

Request to Withdraw Violation due to Resident DME not identifying hearing needs nor noting a diagnosis indicating Resident is (Exhibit 7)

Flasher in Resident Room is standard model and is in proper operating condition (Exhibit 8)

By 4/15/24, Community has scheduled the contracted Fire Safety Expert (Kroger) to conduct a Fire Safety Inspection, which will assess operational status and appropriateness of alarm equipment, including flashers (Exhibit 9)

Licensee's Proposed Overall Completion Date: 04/09/2024

Implemented - 06/11/2024

132a - Monthly Fire Drill

4. Requirements

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

Description of Violation

The home did not conduct a fire drill in April 2023 or January 2024. REPEAT VIOLATION 5/2/23

Plan of Correction

Accept - 04/08/2024

As of 3/28/24, Community has contracted with Fire Safety Company (Kroger) to conduct monthly fire drills on rotating shifts (Exhibit 10)

Starting 4/15/24, Maintenance Director will document monthly fire drills on Fire Drill Log (Exhibit 11)

On 3/27/24, Maintenance Director has completed the State Certified Fire Safety Training through SeniorLivingU.

Executive Director (ED) will monitor Fire Drill Log monthly to ensure fire drill is held monthly and within Regulatory standards

132b – Safety Inspection/Fire Drill

By 4/15/24, Community has scheduled contracted Fire Safety Expert (Kroger) to conduct a Fire Safety Inspection and Fire Drill (Exhibit 9)

By 5/4/24, ED or Designee will educate current staff on Evacuation Time designated within Fire Safety Letter (Exhibit 10)

Licensee's Proposed Overall Completion Date: 05/31/2024

Implemented - 06/11/2024

132b - Safety Inspection/Fire Drill

5. Requirements

132b Safety Inspection/Fire Drill (continued)

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 has not had a fire safety inspection completed since 9/16/22.

Plan of Correction

Accept [redacted] - 04/08/2024)

By 4/15/24, Community has scheduled contracted Fire Safety Expert (Kroger) to conduct a Fire Safety Inspection and Fire Drill (Exhibit 9)

By 5/4/24, ED or Designee will educate current staff on Evacuation Time designated within Fire Safety Letter (Exhibit 10)

Licensee's Proposed Overall Completion Date: 05/31/2024

Implemented [redacted] 06/11/2024)

132d Evacuation

6. 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

Due to not having an evacuation time in writing from a fire safety inspector, the home has the state-issued evacuation time of 2 1/2 minutes. On the following dates and times, the home exceeded this evacuation time during a fire drill:

- 2/6/23 at 3:30am, evacuation time of 7min 49sec
- 3/30/23 at 3:10pm, evacuation time of 5min 10sec
- 5/9/23 at 3:50pm, evacuation time of 5min 1sec
- 6/14/23 at 11:05pm, evacuation time of 7min 38sec
- 7/26/23 at 10am, evacuation time of 4min 56sec
- 8/30/34 at 9:23am, evacuation time of 7min 13sec
- 9/30/23 at 10:55am, evacuation time of 7min 13sec
- 10/23/23 at 5:25pm, evacuation time of 5min 13sec
- 11/23/23 at 2:30pm, evacuation time of 6min 2sec
- 12/23/23 at 12:30pm, evacuation time of 4min 51sec

Plan of Correction

Accept [redacted] - 04/08/2024)

By 4/15/24, Community has scheduled contracted Fire Safety Expert (Kroger) to conduct the Fire Safety Inspection and Fire Drill. (Exhibit 9)

By 4/20/24, Fire Safety Expert (Kroger) will provide ED with Fire Safety Letter with designated Evacuation Time (Exhibit 11)

By 5/4/24, ED or Designee will educate current staff on Evacuation Time designated within Fire Safety Letter (Exhibit 10)

132d Evacuation (continued)

ED will ensure ongoing compliance by scheduling Annual Fire Safety Inspection and obtaining updated Fire Safety Letter.

Licensee's Proposed Overall Completion Date: 05/31/2024

Implemented () - 06/11/2024)

182b - Prescription Medication

7. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

Staff Person A administered medications to residents on (). Staff Person A is not certified to administer medications to residents.

Plan of Correction

Accept () - 04/08/2024)

As of 2/29/24, Employee A and Executive Director at time of violation are no longer employed by Maiden Creek Place nor Inspirit Senior Living (Exhibits 12 and 13)

On 1/5/24, Resident Wellness Director (RWD) audited the current Med Tech documentation to confirm compliance with Regulatory standards (Exhibit 14)

Beginning 4/15/24, RWD will audit the weekly staff schedule to ensure a credentialed medication administering staff member (LPN or Med Tech) is scheduled to be in the Community daily on each shift x 3 months (Exhibit 15)

RWD or Designee will ensure ongoing compliance by monitoring the weekly schedule of credentialed medication administering staff.

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented () - 06/11/2024)

187a - Medication Record

8. Requirements

2600.

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

Description of Violation

The following residents' medication records were not completed to indicate that the specified medications were administered:

Resident #2's () on ()

Resident #3's (), and () eye drop on (), and ()

Resident #4's () at ()

187a Medication Record (continued)

On [redacted] resident #9's medication administration record did not reflect the updated concentration change for [redacted] to the new prescription of [redacted]

REPEAT VIOLATION 5/2/23 et al.

Plan of Correction

Accept [redacted] - 04/08/2024)

As of 1/27/24, the Community has transitioned from use of paper MARs to the Eldermark EMAR system.

By 4/13/24, Resident Wellness Director or Designee will retrain all Registered Medication Aides on Community's Medication Management Policy. (Exhibit 12)

Resident Wellness Director or designee will ensure that medications are administered in accordance with the physician's instructions and consistent with the standards of practice.

Resident Wellness Director, Resident Care Director or designee will provide frequent and routine oversight to the medication program to ensure accuracy, correctness and proper documentation to include holes or omissions in EMAR's/MAR's.

Executive Director will provide oversight to ensure compliance.

Date to be corrected: Immediately and ongoing

Licensee's Proposed Overall Completion Date: 05/31/2024

Implemented [redacted] - 06/11/2024)

187d - Follow Prescriber's Orders

9. Requirements

2600.

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

Description of Violation

Resident #9 is prescribed [redacted]. However, resident #9 was administered [redacted] on [redacted].

Plan of Correction

Accept [redacted] - 04/08/2024)

As of 1/27/24, the Community has transitioned from use of paper MARs to the Eldermark EMAR system.

By 4/13/24, Resident Wellness Director or Designee will retrain all Registered Medication Aides on Community's Medication Management Policy. (Exhibit 12)

Resident Wellness Director or designee will ensure that medications are administered in accordance with the physician's instructions and consistent with the standards of practice.

Resident Wellness Director, Resident Care Director or designee will provide frequent and routine oversight to the medication program to ensure accuracy, correctness and proper documentation to include holes or omissions in EMAR's/MAR's.

Executive Director will provide oversight to ensure compliance.

Date to be corrected: Immediately and ongoing

Licensee's Proposed Overall Completion Date: 05/31/2024

Implemented [redacted] 06/11/2024)

225c - Additional Assessment

10. Requirements

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

Description of Violation

Resident #5's most recent assessment and support plan (RASP) was completed [REDACTED]
 Resident #6's (RASP) was completed [REDACTED]. These residents' RASPs are out-of-date.

Plan of Correction

Accepted [REDACTED] - 04/08/2024)

By [REDACTED], ED will Audit current Resident RASPs to confirm completion within Regulatory Guidelines (Exhibit 13)
 Starting 5/6/24, RWD will audit Annual and Significant Change RASPs weekly to confirm ongoing compliance x 3 months (Exhibit 14)
 ED or Designee will monitor to ensure ongoing compliance

Licensee's Proposed Overall Completion Date: 07/31/2024

Implemented [REDACTED] - 06/11/2024)

227d - Support Plan Medical/Dental

11. 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 #7 is currently receiving hospice services. The resident's RASP, dated [REDACTED] does not include documentation of the resident's hospice services.

REPEAT VIOLATION 6/9/23 et al., 5/2/23 et al., 3/28/23

Plan of Correction

Accepted [REDACTED] - 04/08/2024)

On [REDACTED] Resident #7 RASP was completed with Hospice indicated (Exhibit 10)
 By [REDACTED], ED will audit current Residents RASPs to confirm 3rd Party Services are documented on RASPs as appropriate (Exhibit 13)
 Starting 5/6/24, RWD will audit 5 current Resident RASPs weekly to verify RASPs are updated with any 3rd Party Services x 3 months (Exhibit 14)
 ED or Designee will monitor for ongoing compliance

Licensee's Proposed Overall Completion Date: 07/31/2024

Implemented [REDACTED] 06/11/2024)

227g -Support Plan Signatures

12. Requirements

227g -Support Plan Signatures (continued)

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #8's RASP dated [REDACTED] did not sign the RASP and there was no indication of if the resident refused to or was unable to sign the RASP.

REPEAT VIOLATION 6/9/23 et al.

Plan of Correction

Accept [REDACTED] - 04/08/2024)

On [REDACTED], Resident's Dtr/POA signed RASP (Exhibit 15)

On [REDACTED], Resident #8 RASP was updated with indication of Resident being unable to sign (Exhibit 15)

By [REDACTED] ED will audit current Residents RASPs to ensure Resident has signed their RASP or that it has been indicated that resident is unable/refused to sign. (Exhibit 13)

Starting [REDACTED], RWD will audit 5 RASPs of current Residents to ensure Resident has signed their RASP or it has been indicated that Resident is unable/refused to sign x 3 months. (Exhibit 14)

ED or Designee will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 07/31/2024

Implemented [REDACTED] - 06/11/2024)