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

May 10, 2024

[redacted], PCHA
LEBANON VALLEY BRETHREN HOME
1200 GRUBB STREET
PALMYRA, PA, 17078

RE: LEBANON VALLEY BRETHREN HOME
1200 GRUBB STREET
PALMYRA, PA, 17078
LICENSE/COC#: 34296

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/20/2024 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEBANON VALLEY BRETHREN HOME* **License #**: *34296* **License Expiration**: *06/14/2024*

Address: *1200 GRUBB STREET, PALMYRA, PA 17078*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *LEBANON VALLEY BRETHREN HOME*

Address: *1200 GRUBB STREET, PALMYRA, PA, 17078*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/08/1990* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *34* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/20/2024*

Inspection Dates and Department Representative

03/20/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *4*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

03/20/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/10/2024*

04/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/22/2024*

Inspections / Reviews *(continued)*

04/22/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/30/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/01/2024*

05/10/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/30/2024*

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

132f - Alternate Exit Routes

1. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

During all fire drills conducted from January 2023 through March 2024, the same exit routes labeled "A,B,C" were used for each fire drill.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

The residents were evacuated using alternative routes as per the regulation.
On the fire drill form, staff documented all fire exits instead of the one that was used each drill.
Education of the regulation and the fire drill form was completed by the PC Administrator to the security officer and maintenance director that oversees the fire drills on 4.8.2024.
Audits will be completed x 2 months and begin with the next fire drill in April 2024.
Results of April and May fire drill audits will be discussed during QA review with the VP of Health Services in June 2024 for further guidance.

Licensee's Proposed Overall Completion Date: *04/15/2024*

Implemented ([redacted] - 05/10/2024)

132h - Designated Meeting Place

2. 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

During the fire drill on 05/15/2023 at 7:00PM, 8 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area as per documentation of the fire safety expert (FSE) that observed the fire drill. FSE documentation states: "8 residents stayed in their rooms due to being past their bedtime."

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

The Personal Care Administrator educated the PC staff, and the security officer and maintenance director that oversees the fire drills on the regulation 4.8.24.
The PC residents were educated on the regulation during the resident council meeting 4.11.24.
Results of April and May fire drill audits will be discussed during QA review with the VP of Health Services in June 2024 for further guidance.

Licensee's Proposed Overall Completion Date: *04/15/2024*

Implemented [redacted] - 05/10/2024)

185a - Implement Storage Procedures

3. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 03/20/2024, the following discrepancies were observed between the readings on Resident 3's glucometer and the readings documented on Resident 3's medication administration record (MAR):

[redacted]

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

The PC Administrator educated the Med techs and LPNS on the regulation as it relates to glucometers and documentation on 4.9.24.
The PC administrator audited all current blood sugar orders to ensure correct documentation 4.12.24.
Random audits will be done by the PC administrator on glucometers and documentation of the blood sugar 2x a week for 4 weeks starting 4.15.24.
Results of the audit will be discussed during QA review with the VP of Health Services in June 2024 for further guidance.

Licensee's Proposed Overall Completion Date: *04/15/2024*

Implemented [redacted] - 05/10/2024)

224a - Preadmission Screen Form

4. 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 1's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

The PC administrator reviewed the regulation and educated herself on the regulation 4.8.24.
The PCA performed a whole house audit of all current preadmission forms on 4.9.24.
An audit will be done on the next 4 admissions of the preadmission screening form by the VP of Health services.
Results of the audit will be discussed during QA review with the VP of Health Services in June 2024 for further guidance.

Licensee's Proposed Overall Completion Date: *04/15/2024*

Implemented ([redacted] - 05/10/2024)

224a - Preadmission Screen Form *(continued)*

227g -Support Plan Signatures

5. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The assessor participated in the development of Resident 2's support plan on 02/26/2024. However, the assessor did not sign the support plan.

Plan of Correction ***Accept [redacted] - 04/16/2024)***

The PCA educated herself on the regulation. 4.8.24.
All current in-house support plans were audited by the PCA on 4.9.24 to ensure signatures.
An audit will be completed on the next 2 admissions by the VP of Health.
Results of the audit will be discussed during QA review with the VP of Health Services in June 2024 for further guidance.

Licensee's Proposed Overall Completion Date: *04/15/2024*

Implemented [redacted] - 05/10/2024)