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

August 29, 2024

[redacted], ADMINISTRATOR
RENAISSANCE HOME PINEBROOK LLC
2 WOODBRIDGE ROAD
ORWIGSBURG, PA, 17961

RE: RENAISSANCE HOME PINEBROOK
2 WOODBRIDGE ROAD
ORWIGSBURG, PA, 17961
LICENSE/COC#: 22755

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2024 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: *RENAISSANCE HOME PINEBROOK* **License #**: *22755* **License Expiration**: *05/20/2025*

Address: *2 WOODBRIDGE ROAD, ORWIGSBURG, PA 17961*

County: *SCHUYLKILL* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *RENAISSANCE HOME PINEBROOK LLC*

Address: *2 WOODBRIDGE ROAD, ORWIGSBURG, PA, 17961*

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

[redacted] of Occupancy

Type: *I-2* **Date**: *08/28/2018* **Issued By**: *West Brinswick Twsp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *36* **Waking Staff**: *27*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *05/21/2024*

Inspection Dates and Department Representative

05/21/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *68* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *5* **Have Physical Disability**: *2*

Inspections / Reviews

05/21/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/17/2024*

08/27/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

Inspections / Reviews *(continued)*

08/29/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *08/27/2024*

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

65g - Annual Training Content

1. 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:
3. Resident rights.

Description of Violation

There was no verification that Staff Member A received Resident Rights training for the 2023 training year.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

The Staff educator was made aware of this employee missing a required training for 2023. We were unable to access the missing training to complete. The 2024 Relias Training Plan will be monitored closely to ensure that all employees complete the required trainings. The administrator will monitor for ongoing compliance.

Proposed Overall Completion Date: 07/01/2024

Directed: Within 10 days of receipt of this directed plan of correction and ongoing:
The administrator will develop a staff training plan that includes the following information:
(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and regularly scheduled volunteer
(2) The required training courses for each person identified in (1).
(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.
The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g.
The home will implement the developed plan. Compliance with the plan will be kept in accordance with 2600.65i and 2600.66c.
In addition, Staff Member A will complete training in resident rights to be applied to their 2023 training year. This training will be completed in addition to any resident rights training to be applied to the 2024 training year.
The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/28/2024*

Implemented ([redacted] - 08/29/2024)

66a - Staff Training Plan

2. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

There was no documentation of a staff training plan for the 2024 training year.

66a - Staff Training Plan *(continued)*

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

Please see attached 2024 Relias Training Plan.
On 6/22/24 the 2024 Relias Training Plan was printed and placed in the DHS binder that is kept in preparation for any DHS inspections.
The Administrator receives the Relias Training information from the Staff Educator and is responsible to have the information on hand. [redacted], Administrator will ensure that the appropriate Relias Training schedule is printed and available at all times and monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/19/2024*

Implemented ([redacted] - 08/29/2024)

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Residents 1's enabler bars were observed to have approximately a 10 x 12 inch opening and were not covered at the time of inspection.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

Resident #1 was not in the facility at the time of the inspection. [redacted] was [redacted] is still currently [redacted] RASP will be updated upon return.
The DOW and Administrator will monitor for ongoing compliance if any other residents should require the use of an enabler.

Proposed Overall Completion Date: 07/01/2024

Directed- Within 3 days of receipt of this directed plan of correction and ongoing:
The identified enabler bar will be replaced or covered to ensure that it is in compliance with FDA guidelines.

Staff will be instructed to check all apparatus used by residents at least once per shift to ensure that it is clean, in good repair, and free of hazards. Staff will be instructed to report any apparatus that is in need of cleaning, repair, or replacement to the administrator or designee immediately. The administrator or designee will ensure that the apparatus is immediately cleaned, repaired, or replaced.
The administrator or designee will complete daily audits on all enabler bars to ensure that they are covered and securely fastened to the bed frame. Written documentation of this audit will be kept and signed by staff member making the weekly checks. This will be made available to the department upon request.
The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/21/2024*

Implemented ([redacted] - 08/29/2024)

85d - Trash Receptacles

4. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

The garbage located in the employee restroom was not covered.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

See attached.
The trash can was replaced that afternoon to a receptacle with a lid. The Administrator will monitor and ensure for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 08/29/2024)

88a - Surfaces

5. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

In the home's activity room, there was an approximate 3' x 6' opening located in the ceiling. The opening was covered loosely with clear plastic, held up by numerous pieces of duct tape. Next to the opening, hanging down approximately 12 inches from a single visible electrical wire, was a four-foot-long light fixture. The corresponding light switch was taped in the off position.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

On 5/16/24 During the extensive repair to our dry sprinkler system, an employee of [redacted] Fire Protection (the company performing the repair) fell through the ceiling causing the hole in the ceiling in the Activity Room. That same employee and [redacted] co-worker covered the hole with plastic and duct tape and took pictures to send to [redacted] (owner of [redacted] Fire Protection). A few days later [redacted] received an email that an insurance adjuster would be out to look and submit the claim for repair. Please see attached picture which was taken on 5/22/24. The ceiling light fixture was removed and a piece of dry wall and cardboard was used to better secure the opening in the ceiling. We are still currently awaiting the repair to be completed by [redacted] Fire Protection.
The Administrator will continue to monitor for compliance and will notify DHS when the repair is completed.

Proposed Overall Completion Date: 07/01/2024

Directed: Within 10 days of receipt of this directed plan of correction and ongoing:

The administrator or designee will check all surfaces daily in the home to ensure that they are clean, in good repair, and free of hazards. Any surfaces found to be in need of cleaning or repair will be cleaned or repaired immediately. A written record of these daily checks will be kept and provided to the department upon request.

The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/28/2024*

88a - Surfaces *(continued)*

Implemented ([redacted] - 08/29/2024)

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

The most current letter from a fire safety expert dated 6/28/2023, states that the home has a maximum evacuation time of 5 minutes 0 seconds. The homes fire drill logs indicated evacuation times that were over the maximum allowable time on the following dates:
8/7/23 – 6 minutes 6 seconds
10/26/23 – 5 minutes 50 seconds
11/15/23 – 6 minutes 2 seconds
12/20/23 – 5 minutes 13 seconds
1/11/24 – 5 minutes 8 seconds
3/8/24 – 6 minutes 26 seconds

Repeat Violation 4/19/2024, et al.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

An extensive repair of the dry sprinkler system was completed a few days prior to the annual inspection. At this time [redacted] awaiting a technician from [redacted] to come to the facility and rewire the dry sprinkler system back into building alarm system. After that is completed the system can be placed back in service. Our annual fire inspection is due this month. [redacted] Fire Safety will be here next week to do annual inspection and I will provide that inspection report when it is available.
The Administrator is responsible for providing documentation of annual fire inspection and monthly fire drill reports reflecting the appropriate time to evacuate the building. [redacted] Administrator will monitor for ongoing compliance as soon as the appropriate steps are met and the annual fire inspection is completed.

Proposed Overall Completion Date: 06/19/2024

Directed: - Within 13 days of receipt of this directed plan of correction and ongoing:
The administrator will staff the home to ensure that all residents can be evacuated out of the home or to a fire safe area as designated in writing by a fire safety expert within the maximum time allowed by the fire safety expert. A fire drill will be completed in July to ensure that all residents can be evacuated in the allotted time specified in writing by a fire safety expert.
The administrator will monitor resident needs and changes weekly to ensure that enough staff are present at all times to safely evacuate the residents. These weekly reviews will be documented in writing by the administrator and provided to the department upon request.
The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/31/2024*

132d - Evacuation *(continued)*

Implemented ([redacted] - 08/29/2024)

144c1 - Smoking Area Guidelines

7. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

Description of Violation

Cigarette butts and smoking receptacles were found in an external area across from room 55a. This area is not specified as the home's designated smoking area.

Repeat Violation: 6/14/2023, 10/18/2023 et al,

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

The Administrator located the smoking receptacle that was not in a designated smoking area. Upon investigation, the Administrator was informed that a resident had moved the receptacle to that location a few days prior. The Administrator did speak with the resident who moved the receptacle and educated the importance of utilizing the designated smoking area and also the importance of not throwing cigarette butts on the ground. The Administrator will continue to walk the grounds each morning the ensure that there is no smoking in undesignated areas and that the designated smoking area is clean and free from butts on the ground.

Proposed Overall Completion Date: 07/01/2024

Directed: - Within 7 days of receipt of this directed plan of correction and ongoing:
The administrator or designee will complete daily checks of the grounds to ensure that the smoking procedures are being adhered to by the residents and staff. A written record of these daily checks will be kept and made available to the department upon request.
All staff and residents will be reeducated regarding the home's smoking policies. Written verification of this reeducation will be kept and provided to the department upon request.
The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/25/2024*

Implemented ([redacted] - 08/29/2024)

183e - Storing Medications

8. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident 2 has a physician order for Lorazapam 0.5mg, one tablet orally twice daily as needed for anxiety. Upon inspection of the medication, it was discovered that the seal containing the single tablet remaining in the medication blister card was punctured and taped.

183e - Storing Medications *(continued)*

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

Immediately after the inspection of the medication cart was completed, [redacted], Director of Wellness destroyed the remaining pill that was taped into the blister pack. Medication was reordered from our pharmacy and a new blister pack arrived the next evening with the daily delivery. The DOW and Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/19/2024*

Implemented ([redacted] - 08/29/2024)

185a - Implement Storage Procedures

9. 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

Resident 4 has an order for Lispro 100 unit/mL Kwikpen, Accuchecks twice daily with meals with sliding scale: 0-250=0units, 251-300=4units, 301-350=6units, 351-400=8units, 401-450=10units and call MD if greater than 450.
On 5/11/24 the resident's Medication Administration Record documents blood glucose readings of 160 at 8am and 142 at 5pm.
On 5/12/24 the resident's Medication Administration Record documents blood glucose readings of 189 at 8am and 203 at 5pm.
On 5/15/24 the resident's Medication Administration Record documents blood glucose readings of 127 at 8am and 134 at 5pm.
The resident's glucometer did not contain the corresponding blood glucose readings for 5/11/24, 5/12/24, or 5/15/24.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

An inservice was done with all LPN's and Med-techs regarding the importance of correctly documenting the blood glucose readings in QuickMar. The Director of Wellness is responsible for doing monthly audits of the glucometers and QuickMar records. The Administrator will monitor for ongoing compliance.

Proposed Overall Completion Date: 07/01/2024

Directed: - Within 7 days of receipt of this directed plan of correction and ongoing:
The administrator will provide education with all staff that pass medications regarding MAR documentation of blood glucose. A written record of this education with staff signatures shall be kept and provided to the department upon request.
The administrator or designee will complete weekly audits of all glucometers and QuickMAR records. Once no errors have been found over a consecutive 4-week period the audits will be completed monthly. The administrator or designee will address any errors found with responsible staff member and take appropriate actions to educate and address the errors. A written record of these audits will be kept and provided to the department upon request.
The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/25/2024*

185a - Implement Storage Procedures *(continued)*

Implemented ([redacted] - 08/29/2024)

187c - Refusal of Medication

10. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident 3 has an order for Insulin Aspart 100 unit/mL Pen, accuchecks before meals with sliding scale: if blood sugars <200=0units, 201-250=2units, 251-300=4units, 301-350=6units, 351-400=8units, 401-450=10units, >450=12units and call MD.
On multiple occasions between 5/1/24 – 5/21/24, the resident was not given the dosage of insulin corresponding to the physician's order. The home reports that the resident often refuses the full dose and chooses to take a lesser dose of insulin. The resident's physician was not notified of the medication refusals.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

Resident #4 uses the Libre Freestyle glucose monitoring system. The resident verbally tells the LPN/med-tech [redacted] result and it is entered into QuickMar. The staff was educated to physically look at the Libre monitor to visually see the accurate blood glucose number prior to entering the number in QuickMar. A conversation took place with the resident to educate the importance of staff looking at the monitor and not relying on [redacted] for the number. A call was also placed to the VA diabetic consultant and [redacted] PCP to inform of the same. An inservice was done with all LPN's and Med tech's to educate that the refusal of the correct dose in the physicians order needs to be documented in QuickMar and the DOW and PCP/VA diabetic consultant must be notified of all refusals. The Director of Wellness and the Administrator will monitor for ongoing compliance.

Proposed Overall Completion Date: 07/01/2024

Directed: Within 7 days of receipt of this directed plan of correction and ongoing:
The administrator will provide education with all staff that pass medications regarding proper checks of resident glucose readings and requirement to notify prescriber of any and all medication refusals. . A written record of this education with staff signatures shall be kept and provided to the department upon request.
In the future, the home will ensure that refusal to take a prescribed medication is reported as required by this regulation.
The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/25/2024*

Implemented ([redacted] - 08/29/2024)

227d - Support Plan Medical/Dental

11. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

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 5 has a physician order for mechanical soft diet. The resident's Assessment and Support plan does not address the resident's special dietary needs
Resident 1's RASP dated [redacted], was not updated to reflect that the resident utilizes an enabler bar on their bed.

Repeat Violation 10/18/2023 et al, 3/21/2024.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

Resident #1 was not in the facility at the time of the inspection. [redacted] was [redacted] is still currently [redacted] RASP will be updated upon return.
Resident #1's RASP was updated to Mechanical Soft diet.
The Director of Wellness [redacted] is responsible to complete and update RASPS when due or to report any changes. The Administrator [redacted] educated the DOW on the importance of completing and maintaining the RASP for each resident. The Administrator will ensure that the DOW is completing and updating each RASP in a timely fashion to reflect any changes. The Administrator will monitor for ongoing compliance.

Proposed Overall Completion Date: 07/01/2024

Directed: - Within 7 days of receipt of this directed plan of correction and ongoing:
The support plan of Resident 5 will be updated to show current diets. The support plan for Resident 1 will be updated to reflect the specific need for the device, the intended use, any risks associated with the device, and the resident's ability to use
the device safely for the intended purpose, identification of the specific device to be used and if a cover is required to
meet FDA guidelines.
The Administrator will check all resident RASP's weekly to ensure necessary changes related to medical, dental, vision, hearing, mental health and/or behavioral health are documented in the record within 5 days of the change. The administrator will keep records of these weekly audits and provide them to the department upon request.

The administrator shall monitor and ensure ongoing compliance.

Directed Completion Date: *07/25/2024*

Implemented ([redacted] - 08/29/2024)