

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

August 6, 2024

[REDACTED], ADMINISTRATOR  
THE HIGHLANDS AT WYOMISSING INC  
2000 CAMBRIDGE AVENUE  
WYOMISSING, PA, 19610

RE: THE HIGHLANDS AT WYOMISSING  
PERSONAL CARE FACILITY  
2000 CAMBRIDGE AVENUE  
WYOMISSING, PA, 19610  
LICENSE/COC#: 20535

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/09/2024 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



Inspections / Reviews (*continued*)

## 08/06/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/06/2024

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document  
Submission*

## 08/06/2024 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/06/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

## 185a - Implement Storage Procedures

**1. 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**

On [REDACTED] Staff Person "A" recorded on the narcotic log sheet that [REDACTED] prefilled [REDACTED] syringes prescribed to Resident #1 were received from the pharmacy. On [REDACTED] it was noted by Staff Person "B" that the count log for this medication indicated 32 syringes however the number of syringes on hand was 30. When investigating the error, the pharmacy was contacted by Staff person "B", and the pharmacist reported they failed to adjust the number of syringes from 32 to 30 on the label before delivery to the home. They further explained that 2 syringes are always wasted so the amount of 30 can be delivered as prescribed by the physician. When questioned, Staff Person "A" confirmed that they did not remove the syringes from the bag to count them and referred only to the pharmacy label which indicated 32.

**Plan of Correction**

Accept [REDACTED] - 08/06/2024)

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.

The Root cause of the violation was Staff Person "A" did not follow procedure by removing syringes from storage bag and individually counting pre-filled syringes, and went off of the incorrect documentation of amount initially received.

When count issue was discovered PCHA and DOW(Staff Person "B") met with Staff Person "A" and she admitted to not following policy by individually counting syringes. Staff Person "A" was suspended pending investigation. DOW contacted Outlook Pharmacy to clarify amount of syringes actually delivered. Pharmacy always sends 30 day supply unless specified from ordering physician (see attached email from Eric Esterbrook, pharmacist). Controlled Substance Record Label reflects 8 ml-30 prefilled syringes, however staff documented 32 received due to miscounting through storage bag.

DOW immediately verbally re-educated all staff on shift to shift controlled substance count and importance of proper documentation. Investigation concluded Staff Person "A" did not follow Controlled Substance policy and was terminated.

Plan of Correction: DOW and PCHA updated Policy(dated 7/30/2024)to include individually counting pre-filled syringes and staff education completed on 7/24/24 and also at new hire and on-going staff meetings.

DOW implemented 2 person signature while logging in the controlled substance upon delivery. DOW audits Controlled Substance Record monthly.

The pharmacy will be notified promptly with any discrepancies with the count. Staff will notify the Director of Wellness immediately with any discrepancies with the count during shift changes.

Licensee's Proposed Overall Completion Date: 08/05/2024

Implemented [REDACTED] - 08/06/2024)