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

March 5, 2025

[redacted], EXECUTIVE DIRECTOR
PHOEBE BERKS HEALTH CARE CENTER, INC.
[redacted]

RE: PHOEBE BERKS VILLAGE
1 READING DRIVE
WERNERSVILLE, PA, 19565
LICENSE/COC#: 20536

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/10/2024, 09/11/2024 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: *PHOEBE BERKS VILLAGE* **License #**: *20536* **License Expiration**: *07/30/2025*

Address: *1 READING DRIVE, WERNERSVILLE, PA 19565*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *PHOEBE BERKS HEALTH CARE CENTER, INC.*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/04/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *113* **Waking Staff**: *85*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/11/2024*

Inspection Dates and Department Representative

09/10/2024 - On-Site: [redacted]

09/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *83*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *na* **Capacity**: *37* **Residents Served**: *30*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

09/10/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/11/2024*

10/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/11/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/20/2024*

Inspections / Reviews *(continued)*

11/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2024*

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

03/05/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *11/19/2024*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home did not post the License Inspection Summary dated 11/28/23 as required.

Plan of Correction ***Accept (- 10/15/2024)***

On 9/12/202 the Administrator placed a copy of License Inspection Summary dated 11/28/2023 in the binder located in the lobby. Administrator or designee will place all inspections into the binder. An audit was completed on 10/7/2024 and placed in the binder (copy attached). Current Licensing Inspection Summaries will be reviewed at the monthly QAPI meetings.

Licensee's Proposed Overall Completion Date: *10/07/2024*

Implemented (- 11/20/2024)

42c - Treatment of Residents

2. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 9/10/24 during the lunch time meal in the memory care unit, department representatives overheard staff person A warning resident #1 that they would have to go to another room to eat if they didn't quiet down. Resident #1 was complaining loudly regarding not being served iced tea immediately. Resident #1 was not treated with dignity and respect by staff person A.

Plan of Correction ***Accept (- 10/15/2024)***

Staff person "A" was reeducated on 9/11/2024 verbally by the interim administrator. All Staff were reeducated on Residents Rights, (see attached) Staff will be monitored for ongoing compliance by the administrator or designee. Resident Rights will be reviewed upon hired, during annual trainings and ongoing. Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/07/2024*

Implemented (- 11/20/2024)

65g - Annual Training Content

3. 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:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

The home did not have documentation that staff persons B, C, and D had fire safety training by a fire safety expert for the annual training year 2023. Staff person B also did not have training in emergency preparedness in 2023. Staff person B was hired . Staff person C was hired Staff person D was hired

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept (- 10/15/2024)***

A Fire Safety Expert from Life Safety Solutions will be on site on Monday, October 14, 2024 to complete the annual fire safety training. Documentation will be forwarded upon completion. Fire Safety Expert will complete annual training to all employees. Administrator or designee will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/14/2024*

Implemented (- 03/04/2025)

96a - First Aid Kit

4. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit stored in the medication room did not have tweezers or a CPR breathing shield in it.

Plan of Correction ***Accept (- 10/15/2024)***

On 9/16/2024 tweezer and CPR breathing shields were placed into the first aid kits. The Administrator made the attached checklist to be placed into each first aid kit to be completed monthly and given to the administrator to monitor for ongoing compliance to be placed into the audits binder. Audit wills be conducted on a monthly basis by the Administrator or designee to monitor for on going compliance.

Licensee's Proposed Overall Completion Date: *10/07/2024*

Implemented (- 11/20/2024)

103e - Left Overs

5. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The refrigerator located in the memory care kitchenette had 2 trays of pie slices in it that were not covered or labeled with the date they were stored in the refrigerator.

Plan of Correction ***Accept (- 10/15/2024)***

9/20/24-9/25/2024 Dietary were reeducated on the Policy of Labeling Food and Beverages (see attached policy and sign in sheet), Administrator or designee will monitor with audits to ensure on going compliance. 1 time per week for 1 month and 1 time a month thereafter. All staff has been educated if they see anything in the refrigerator not labeled and/or dated to remove the items and throw it into the trash can. Signs have been placed on the refrigerator doors in small kitchen areas reminding staff to date, label and initial any food items prior to placing it into the refrigerator.

Licensee's Proposed Overall Completion Date: *10/07/2024*

Implemented (- 11/20/2024)

103g - Storing Food

6. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

French toast sticks were found in the freezer of the memory care kitchenette in a plastic bag that was torn and not sealed properly. There was a metal container of butter stored on the counter of the 2nd floor kitchenette that was not covered.

Plan of Correction ***Accept (- 10/15/2024)***

French toast sticks were removed on the day of the inspection and disposed of. Staff was reeducated on the policy of proper food storage. Audits will be done weekly for 1 month and 1 time per month for 3 months. Administrator or designee will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/08/2024*

Implemented (- 11/20/2024)

125a - Combustible Storage

7. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A slipper sock was found behind the dryer located in the memory care laundry room, posing a fire hazard. Repeated violation 9/27/23 et al.

Plan of Correction ***Accept (- 10/15/2024)***

The sock was removed on the day of inspection. On 10/1/2024 the lint cleaning log was updated to include checking behind the dryer for items that may have fallen behind the dryer. On September 12, 2024 a grabber was also placed in the laundry room to reach items that may have fallen on the floor behind the dryer to make it easy to retrieve the item. A copy of the log will be maintained in the Administrator's office in the audit binder. Ongoing compliance will be monitored by administrator or designee.

Licensee's Proposed Overall Completion Date: *10/09/2024*

Implemented (- 11/20/2024)

131f - Fire Extinguisher Inspection

8. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher found in the memory care kitchenette had a tag indicating the inspection expired in August of 2024.
The fire extinguisher found in the 2nd floor pantry also had a tag indicating the inspection expired in August of 2024.

Plan of Correction ***Accept (- 10/15/2024)***

On September 9, 2024 replaced the fire extinguisher in the second floor kitchen (copy attached).

131f - Fire Extinguisher Inspection (continued)

Facilities Maintenance will do monthly audits of the fire extinguishers and document the inspection. Administrator or designee will monitor for ongoing compliance

Licensee's Proposed Overall Completion Date: *10/10/2024*

Implemented (- 11/20/2024)

132d - Evacuation

9. 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

On 11/29/23 at 3:30pm the home conducted a fire drill with an evacuation time of 9 minutes and 49 seconds. The home's fire safety inspection letter dated 5/2/23 indicates the home's maximum safe evacuation time to be 8 minutes. Repeated violation 9/27/23 et al.

Plan of Correction ***Accept (- 10/15/2024)***

On January 18, 2023 a Fire Safety Expert inspected the building and based on the design of the facility the evacuation time as required by 2600.132(d), from the resident area to the designated areas of refuge (fire safe areas) as identified to the exterior of the building shall be a maximum of fifteen minutes (copy attached) Fire Safety Expert will continue with yearly inspections and provide documentation regarding the time allotted for evacuation. Administrator or designee will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/09/2024*

Implemented (- 11/20/2024)

132g - Fire Drills Days/Times

10. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home's fire drill logs indicate that the last 8 fire drills were held in the last half of the month and often in the last week of the month. The home is not varying the times of the month in which fire drills are held. Drill dates: 1/24/24, 2/23/24, 3/28/24, 4/23/24, 5/23/24, 6/27/24, 7/24/24, 8/20/24.

Plan of Correction ***Accept (- 10/15/2024)***

On October 3, 2024 the fire safety expert has been made aware of this violation and has varied the time of the month and days of the week in which fire drills will be held. Documentation shall be maintained in the fire safety binder in the Administrator's office. Administrator or designee will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/09/2024*

Implemented (- 03/04/2025)

132h - Designated Meeting Place

11. 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

On 10/27/23 the home conducted a fire drill at 2:05pm. During the drill the resident in room [redacted] refused to evacuate. Also, on 12/29/23 the home conducted a fire drill at 4:07pm and the resident in room [redacted] refused to evacuate. Repeated violation 9/27/23 et al.

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

Both Residents were educated on September 12, 2024 on the requirement of having to evacuate when the fire alarm sounds or the facility has the right to issue a 30 day notice for noncompliance. Both Residents agreed to comply with this regulation. During the most recent Fire Drill all Residents evacuated. At Resident Council meeting on October 16, 2024 all Resident will be reeducated on the importance of evacuating when the fire alarm sounds. Administrator or designee will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/16/2024*

Implemented ([redacted] - 03/04/2025)

141a 1-10 Medical Evaluation Information

12. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2'S Document of Medical Evaluation (DME) form signed [redacted] does not include the date the resident was evaluated or the date the form was completed.
Resident #3 was admitted to the home on [redacted] Resident #3's DME dated [redacted] shows a corrected date of evaluation and date of the form being completed. There is no indication there was authorization of the change or the date and time the contact made to be given authorization to make the change.

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

Resident # 2's MD was notified via fax and approved the correct date of the evaluation and and the date the form was completed, MD agreed to change (see attached)
Resident #3's MD was notified via fax and provided the correct date that was seen on [redacted] (see attached)
A excel tracking sheet has been created to ensure DMEs and RASPs are completed in a timely manner. The

141a 1-10 Medical Evaluation Information (continued)

DME/RASP tracker will be reviewed at the monthly QA meeting to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/08/2024*

Implemented (- 11/20/2024)

183e - Storing Medications

13. 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

The expiration date of the Lispro insulin pen belonging to resident #5 indicated the pen expired on 9/4/24.

Plan of Correction ***Accept (- 10/15/2024)***

A med cart audit was completed on 9/26/2024 by the Nurse Manager on all medication carts in the building (see attached) Audits will be done on a weekly basis and placed into the audits binder. Ongoing compliance will be monitored by the Administrator or designee.

Licensee's Proposed Overall Completion Date: *10/09/2024*

Implemented (- 11/20/2024)

185a - Implement Storage Procedures

14. 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 #6's glucometer was not calibrated to the correct time.
Resident #6's blood glucose reading was recorded incorrectly on 9/8/24 for the morning reading. At 8:38am the glucometer indicated a glucose reading of 258 which was recorded as 283 on the Medication Administration Record (MAR). Also, on 9/8/24 at 4pm the glucometer indicated a glucose reading of 252 but was recorded as 219 on the MAR.

Plan of Correction ***Accept (- 10/15/2024)***

Resident # 6's glucometer was recalibrated to the correct time on 9/12/2024 by the Administrator. Glucometers will be audited and recalibrated, as needed, on a weekly basis and documented on the audit sheet (see attached). The audit sheets will be maintained in the audit binder in the Administrators office. Administrator or designee will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/09/2024*

Implemented (- 03/04/2025)

187b - Date/Time of Medication Admin.

15. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

187b - Date/Time of Medication Admin. *(continued)*

Description of Violation

Resident #7 has an order for Lorazepam .25mg every six hours daily. On 9/9/24 the controlled drug sheet for this medication indicates it was administered at 7am. The resident's MAR was not initialed for this administration on 9/9/24 at 7am.

Plan of Correction ***Accept (- 10/21/2024)***

The electronic medication administration record was down due to an outage on 9/9/2024. On September 26, 2024 a training was held with the Administrator who was taught how to run back up MARs on paper and place them in the appropriate binders marked for each medication cart, in the event of an outage. In the event of an electronic MAR outage the Administrator will be notified immediately so that she can come into community, print the paper MARS and place them into the appropriate binders in the medication cart. Ongoing compliance will be monitored by the Administrator.

Licensee's Proposed Overall Completion Date: *10/15/2024*

Implemented (- 01/22/2025)

187d - Follow Prescriber's Orders

16. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 has an order for Novalog insulin to be administered on a sliding scale twice daily in the morning and afternoon. On 9/8/24 the resident's morning glucose reading was 258 requiring 4 units of sliding scale insulin. The MAR indicates no sliding scale units were administered. Also, on 9/8/24 the resident's afternoon glucose reading was 252 requiring 4 units of sliding scale insulin. The MAR indicates the home administered 2 units of sliding scale insulin. Resident #7 has an order for Lorazepam .5mg every 6 hours. On 9/8/24 the medication was not administered at 6am. Resident #8 has an order for Novolog insulin to be administered on a sliding scale twice daily in the morning and afternoon. On 9/7/24 in the afternoon there is a glucose reading of 284 with 6 units of insulin administered for the reading. Resident #8's glucometer did not have an afternoon glucose reading verifying the resident required 6 units of sliding scale insulin.
On 9/8/24 the home experienced technical issues with their electronic MAR system. As a result, Resident #6 did not receive their 6:30am administration of Levothyroxine.
Also on this date, resident #9 did not receive their 8am administration of Metoprolol 25mg due to the system outage.

Plan of Correction ***Accept (- 10/15/2024)***

On 10/9/2024 staff was reeducated on the medication administration policy (see attached policy and sign off sheet). Weekly cart audits are being done by the nurse manager and placed in the audit binder in the administrator office. The electronic medication administration record was down to an outage 9/9/2024. On September 26, 2024 a drill was held with the Administrator to run back up MARs on paper and place them in the appropriate binders marked for each medication cart, in the event of an outage. The Administrator or designee will monitor for ongoing compliance and reviewed at the monthly QAPI meetings.

Licensee's Proposed Overall Completion Date: *10/10/2024*

Implemented (- 01/22/2025)

190a - Completion Medication Course

17. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C completed initial med tech training on [redacted]. Staff person C did not complete an annual practicum until March 2024.

Plan of Correction ***Accept ([redacted] - 10/21/2024)***

On 9/30/2024 the Staff Development Coordinator, Medication Administration Trainer completed the medication administration course with staff person C (attached). The Administrator or designee will monitor for ongoing compliance and compliance will be monitored during monthly QAPI meetings.

Licensee's Proposed Overall Completion Date: *10/15/2024*

Implemented ([redacted] - 11/20/2024)

225a - Assessment 15 Days

18. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4 was admitted to the home on [redacted] An initial assessment was not completed for the resident until [redacted]. An initial assessment was not completed within 15 days of admission.
Resident #10 was admitted to the home on [redacted]. An initial assessment was not completed for the resident until [redacted] An initial assessment was not completed within 15 days of admission.

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

On 10/10/2024 an audit of all new admissions was completed to ensure assessment form is completed within 15 days of admission. Administrator and or designee will continue audits of all Residents utilizing the attached DME/RASP tracker. All new Residents will be added to the sheet to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/10/2024*

Implemented ([redacted] - 11/20/2024)

225c - Additional Assessment

19. Requirements

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

Description of Violation

Resident #11 was admitted to the home on [redacted] The resident's most recent support plan was completed [redacted]. The home did not have documentation of a support plan completed in 2023.

225c - Additional Assessment (continued)

Resident # 12 was admitted to the home on [redacted]. The resident's most recent support plan was completed [redacted] The home did not have documentation of a support plan completed in 2022.

Plan of Correction ***Accept ([redacted] - 10/21/2024)***

On 10/10/2024 an audit of all new admissions was completed to ensure assessment form is completed within 15 days of admission. Administrator and or designee will continue audits of all Residents utilizing the attached DME/RASP tracker. All new Residents will be added to the sheet to ensure ongoing compliance. The Administrator or designee will monitor for ongoing compliance utilizing the tracker sheet.

Licensee's Proposed Overall Completion Date: *10/15/2024*

Implemented ([redacted] - 11/20/2024)

227d - Support Plan Medical/Dental

20. 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 13# has an enabler bar attached to their bed. The support plan dated [redacted] does not include this information as well as the following required information:
• any risks associated with the device
• ability to use the device safely
• identification of the device
• if FDA requires a cover.
Resident #1 has an enabler bar attached to their bed. The support plan dated [redacted] is missing the following required information
• any risks associated with the device
• ability to use the device safely
• identification of the device
• if FDA requires a cover.
Resident #2's support plan dated [redacted] does not address any behavior or cognitive care. Pages 10 and 11 of the support plan used to capture this information are blank.

Plan of Correction ***Accept ([redacted] - 10/15/2024)***

An audit was completed on October 5, 2024 and any Resident with an enabler bar the RASP was updated to include: any risks associated with the device
• ability to use the device safely
• identification of the device
• if FDA requires a cover.
Resident #1 has an enabler bar attached to their bed. The support plan was update on 10/10/2024 to include, any risks associated with the device, ability to use the device safely, identification of the device, if FDA requires a cover.

227d - Support Plan Medical/Dental (continued)

Resident # 2's support plan was 10/10/2024 to address any behavior or cognitive care. Administrator or designee will audit for ongoing compliance and report at monthly QAPI meetings.

Licensee's Proposed Overall Completion Date: *10/10/2024*

Implemented (- 01/22/2025)

227g -Support Plan Signatures

21. Requirements

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

Description of Violation

Resident #'2s support plan dated was not signed by the person completing the support plan.

Plan of Correction ***Accept (- 10/15/2024)***

Resident #2's support plan was signed on 9/12/2024 by the nurse that completed it. Administrator or designee will monitor for on going compliance by utilizing the DME/RASP completion due spread sheet.

Licensee's Proposed Overall Completion Date: *10/10/2024*

Implemented (- 03/04/2025)

231c - Preadmission Screening

22. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #13 was admitted to the home's secure dementia unit on The home did not complete a cognitive preadmission screening within 72 hours prior to the resdient's admission to the secure unit.

Plan of Correction ***Accept (- 10/21/2024)***

On 9/16/2024 the Interim Administrator and Staff Development Coordinator completed an audit of all charts to ensure the screening was completed as required by this regulation. Administrator and/or designee will continue to complete audits on all new Residents and document compliance in the audit book located in the Administrator's office.

Licensee's Proposed Overall Completion Date: *10/15/2024*

Implemented (- 11/20/2024)

236 - Staff Training

23. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Staff persons C and D did not complete the required additional 6 hours of dementia training for the 2023 training

236 - Staff Training (continued)

year. Staff person C completed 2 hours of dementia training and staff person D completed 3 hours of dementia training in 2023.

Plan of Correction ***Accept (- 10/15/2024)***

On 1/30/2024 Staff person C completed Dementia training, staff person D has been assigned Dementia training and is completing it. The 6 hours of dementia training for the year 2024 have been added to all staff in the dementia unit. Audits of all staff in the dementia unit will be completed by November 1, 2024, to make sure trainings are completed. The Administrator or designee will monitor for ongoing compliance

Licensee's Proposed Overall Completion Date: *10/31/2024*

Implemented (- 03/04/2025)