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

November 13, 2024

[redacted], ADMINISTRATOR
PHOEBE HOME INCORPORATED
1925 TURNER STREET
ALLENTOWN, PA, 18104

RE: MILLER PERSONAL CARE AT 19TH AND CHEW
1925 TURNER STREET
ALLENTOWN, PA, 18104
LICENSE/COC#: 21617

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/08/2024 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**: *MILLER PERSONAL CARE AT 19TH AND CHEW* **License #**: *21617* **License Expiration**: *12/08/2024*

**Address**: *1925 TURNER STREET, ALLENTOWN, PA 18104*

**County**: *LEHIGH* **Region**: *NORTHEAST*

## Administrator

**Name**: [redacted]

## Legal Entity

**Name**: *PHOEBE HOME INCORPORATED*

**Address**: *1925 TURNER STREET, ALLENTOWN, PA, 18104*

**Phone**: [redacted]

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *02/09/1988* **Issued By**:

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *53* **Waking Staff**: *40*

## Inspection Information

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

**Reason**: *Renewal, Complaint* **Exit Conference Date**: *10/08/2024*

## Inspection Dates and Department Representative

*10/08/2024 - On-Site* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *60* **Residents Served**: *45*

### 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**: *45*

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

**Have Mobility Need**: *8* **Have Physical Disability**: *1*

# Inspections / Reviews

### 10/08/2024 Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/02/2024*

### 11/05/2024 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *11/06/2024*

**Reviewer**: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/10/2024*

## Inspections / Reviews *(continued)*

**11/13/2024 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *11/06/2024*

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

## 5a1 - DHS Access

**1. Requirements**

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

**Description of Violation**

*On 10-8-24 an agent of the Department requested access to staff records for staff person A and Staff person B at 1025am but the records did not fully arrive until 1:20pm.*

**Plan of Correction** ***Accept ( - 11/04/2024)***

*The root cause was the result of a gap in communication and oversight between the Aramark Director, the administrator, and the staff development coordinator regarding the staff members records. As a result, paperwork from the HCC arrived much later than planned. A system of internal reporting has been established to ensure any potential issues are addressed before they result in violations. The administrator will receive ongoing professional development in regulatory compliance through email or telephone communication with non Phoebe managers regarding their employees. This POC has been implemented as of 10/9/24 with the Aramark Director. It will be the responsibility of the Staff Development Coordinator, Administrator, or designee to notify all departments when DHS arrives to ensure all are aware of potential paperwork necessary are delivered in a timely manner regarding their particular employees.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented ( - 11/13/2024)***

## 17 - Record Confidentiality

**2. Requirements**

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

**Description of Violation**

*During the initial walkthrough, a binder with Narcotic Controlled Drug sheets for several residents was found stored on a table across from the medication cart on 2nd floor. The binder contained residents' confidential information and was accessible to persons other than staff and the residents.*

*Repeated Violation: 3-7-24 et al.*

**Plan of Correction** ***Accept - 11/04/2024)***

*See attached. Please see final page where all relevant staff have completed the refresher training on this regulation. Upon identification of the issue, the NARC book was immediately secured in the medication cart and the staff person was reminded of the protocol for handling not only controlled substance documentation but for security and confidential resident information being accessible to anyone. A daily checklist has been implemented requiring staff to confirm that NARC book is secured at the end of each shift. Supervisor, or charge nurse, will conduct random audits throughout the day during rounds to ensure that books are secure and will immediately address any issue with Medication Technician as needed. This will be immediate and ongoing with responsibility of the Med Tech.*

## 17 Record Confidentiality (continued)

*The charge nurse will conduct regular audits to confirm that the book is consistently stored securely. Administrator will spot check during daily rounds and any non compliance issues will be addressed immediately leading to disciplinary action to ensure compliance is met. {Nurse and administrator ongoing daily}*

**Licensee's Proposed Overall Completion Date:** *10/25/2024*

***Implemented ([redacted] - 11/13/2024)***

## 42s - Privacy

**4. Requirements**

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

**Description of Violation**

*The home has cameras installed throughout the building that record common areas of the home including the dining area and the living room area.*

**Plan of Correction** ***Accept [redacted] - 11/05/2024)***

*See attached. As of 10/10/24, signs have been posted in visible areas to inform all residents, staff, and visitors about the presence of security cameras. While it was an oversight, facility maintenance members and security have received updated training on compliance requirements regarding the visible signage for privacy awareness. Routine audits will be conducted by maintenance manager to confirm that all existing signage remain visible and intact on both front and back doors and to ensure compliance is met with this regulation.*

**Licensee's Proposed Overall Completion Date:** *10/25/2024*

***Implemented [redacted] - 11/13/2024)***

## 81b - Resident Personal Equipment

**5. 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**

*Resident # 2 in room 401 had a wide U shaped enabler bar attached to their bed. The bars had a space of approximately 10 inches across that was not covered to prevent entrapment.*
*Repeated Violation: 1 30 24 et al.*

**Plan of Correction** ***Accept ([redacted] - 11/05/2024)***

*See attached. The resident has refused to keep her enabler bar covered as she states she cannot get a good grip with the covering and it does not feel safe to her[redacted] states[redacted] hand slides and it is[redacted] personal preference to uncover it. [redacted] has been counseled of the importance of this regulation several times by the staff as well as the nurse and administrator who continually place it back on to ensure safety is met. The staff will continue to cover the bar while reeducating her on the risks of not covering it offering supportive counseling. The care plan has now been updated to reflect her preference on 10/9/24. We will continue to care plan for non compliance. Administrator will reach out to resident's son requesting a conversation be had to help[redacted] understand the safety of meeting this regulation. Staff will continue to ensure compliance with daily regular checks and shift rounds. Administrator will spot check daily during rounds and will regularly reeducate on the safety vs risks associated with the enabler bar. This will be*

## *81b Resident Personal Equipment (continued)*

*ongoing to ensure overall compliance.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented [redacted] - 11/13/2024)***

## 82a - Poisonous Materials

**6. Requirements**

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

**Description of Violation**

*During the initial walk through, a plastic spray bottle containing a clear liquid was found in a 4th floor cleaning cart and another bottle was observed on a counter in the nearby kitchen. The spray bottles did not have manufacturer's labels identifying the contents. Staff confirmed the bottles both contained disinfectant cleaner.*

**Plan of Correction** ***Accept [redacted] - 11/05/2024)***

*See attached. All poisonous and hazardous materials were labeled while inspectors were present and completed on 10/9/24. The root cause was determined to be staff oversight and lack of clear labeling procedures. New procedures have been implemented by Dining manager who took immediate action and in serviced staff on 10/9/24. She and her staff will continue with ongoing daily paperwork as attached to prevent future occurrences. A thorough safety inspection of all storage areas was conducted to ensure that no unlabeled materials remain. All staff will receive annual training on proper handling and labeling of poisonous and hazardous materials with additional trainings for new hires by our Staff Development Coordinator. Housekeeping will be responsible to double check materials used for proper labels. They will remove and label if necessary. Dining Manager and administrator will do daily spot checks to ensure compliance.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented [redacted] - 11/13/2024)***

## 85d - Trash Receptacles

**7. 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**

*During the initial walk through a trash bag full of leftover Styrofoam containers used to serve breakfast was found on the floor of the 2nd floor kitchenette/small dining area. The bag was not sealed with a twist tie.*

*During the initial walk through of the home on 10 8 24, the Garbage can in the 4th floor kitchen was observed without a lid.*

*Repeated Violation: 1 30 24 et al.*

**Plan of Correction** ***Accept [redacted] - 11/05/2024)***

*See attached. The trash bag found during breakfast walkthrough was left open since breakfast wasn't entirely finished by all. It was left untied to accommodate remaining waste. To prevent this from happening in the future, we will set an additional time for collecting waste after everyone has finished their meal. This is not a normal practice*

## 85d - Trash Receptacles (continued)

*for our community but was a result of our elevator service disrupted. Nursing staff had been in serviced on this regulation on 10/10, 10/15, and 10/16 by the administrator. Our dining manager has taken steps to prevent reoccurrences in our 4th floor kitchen area. These measures started on 10/9/24 and will be daily and ongoing by the supervisors. Please see samples of the compliance form Miller labeling, dating, food storage, and sanitation audit. The dining supervisor will be responsible daily and turn into the dining manager to ensure this process in being followed. Should dining service manager not receive the form after each days completion, [redacted] will notify supervisor and disciplinary measures will be taken. Responsibility will be the dining manager. Administrator will do daily rounds in the kitchen area which started on 10/10/24.*

**Licensee's Proposed Overall Completion Date:** *10/28/2024*

***Implemented [redacted] - 11/13/2024)***

## 95 - Furniture and Equipment

**8. Requirements**

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

**Description of Violation**

*On 9/18/24 the home reported that they were unable to use the elevator and were waiting for repair parts. The elevator was eventually repaired on 9/30/24. Staff and resident interviews conducted indicated that some residents on the 2nd and 3rd floors were unable to use the steps to exit the building. Resident # 2 was interviewed and indicated their spouse, resident # 3, had to cancel a doctor appointment during the time the elevator was broken due to resident # 3 being unable to descend the stairs. Staff also indicated that resident # 4 missed a doctor appointment during the time the elevator was not functioning.*

**Plan of Correction** ***Accept ([redacted] - 11/05/2024)***

*See attached. As a result of this violation, all staff were retrained on how to use the Stryker chair located in the stairwells. This regulation will be addressed with the residents on 11/7/24 at the resident council meeting to ensure they are safe and comfortable with having staff safely bringing them to the 1st floor if they choose to go to outside appointments in the event the elevator is not working. Certain residents refused to use alternate methods. Our charge nurse spoke with resident #2 about keeping this appointment for resident #3. {Resident makes all of her own appointments for both herself and resident #3} Resident did not feel comfortable with resident #3 being placed on the chair and brought to the 1st floor due to the curvature in resident #3's back and being brought down 3 flights of stairs. [redacted] opted to cancel despite the reassurance given to [redacted]. Resident #4 also makes [redacted] own appointments and did not make staff aware [redacted] had a scheduled appointment. All paperwork is made prior to appointments for resident convenience. They stop by the nurses station, pick it up, and return with any new orders upon return form doctor's office. Since no paperwork was present we were unaware of any appointments or cancellations. Resident #4 is capable of descending the staircase with assistance. Administrator will also reiterate this at resident council as we make all paperwork prior to any appointment so resident can take it with them for continuity of care. Our nurse spoke with resident #4 and learned [redacted] opted to cancel her appointment as she didn't feel like "doing the steps" that day. [redacted] was informed of the safety of our staff using the Stryker chair moving forward. Administrator will be responsible for counseling on the importance of attending medical appointments. Also [redacted] will educate on the safe and proper use of the chair to alleviate concerns or fears at the meeting on 11/7/24.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented [redacted] - 11/13/2024)***

## 103e Left Overs

**9. 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**

*A small Styrofoam container of orange sherbert was found in the 3rd floor kitchenette freezer with no date or label to indicate when it was stored in the freezer.*

*Repeated Violation: 1-30-24 et al.*

**Plan of Correction** ***Accept ( - 11/05/2024)***

*See attached. This container was removed while inspectors were present. All unlabeled and undated food items have been removed and discarded by dining manager on 10/9/24. An in-service was held on 10/9/24 and will be ongoing using the supervisors checklist--see attached. An overall audit will be done on top of the daily paperwork by the supervisor or Exec. Chef on duty every 2 weeks to ensure compliance is maintained. Corrective actions will be documented by the dining manager. Kitchen staff will be held accountable for ensuring that all food items are properly labeled and dated. Failure to follow proper procedure will result in corrective measures including additional training or disciplinary action. All dining personnel will receive annual training on food safety, including labeling and dating of food. This will be conducted by the staff development coordinator and the executive check or dining manager and will be ongoing as needed.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented ( - 11/13/2024)***

## 103g Storing Food

**10. Requirements**

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

**Description of Violation**

*During the physical site inspection 4 glass dishes of leftover cut fruit were found in the 4th floor kitchen refrigerator.*

*Repeated Violation: 1-30-24 et al.*

**Plan of Correction** ***Accept ( - 11/05/2024)***

*See attached. The leftover fruit dishes were removed while inspectors were present. All uncovered food was discarded by dining manager on 10/9/24. Dining manager held an in-service on 10/9/24 regarding this regulatory compliance. An overall audit will be done on top of the daily paperwork by the supervisor or Exec. Chef on duty every 2 weeks to ensure compliance is maintained. Corrective actions will be documented by the dining manager. Kitchen staff will be held accountable for ensuring that all food items are properly covered and stored in sealed containers. They are to label and date as necessary. Failure to follow proper procedure will result in corrective measures including additional training or disciplinary action. All dining personnel will receive annual training on food safety, including labeling and dating of food and storing in sealed or closed containers. This will be conducted by the staff development coordinator and the executive check or dining manager and will be ongoing as needed.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented ( - 11/13/2024)***

## 132g - Fire Drills Days/Times

**11. 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 routinely holds fire drills between the 23th and 28th of the month as evidenced by the following drills:*
*1-23-24*
*2-27-24*
*3-28-24*
*4-25-24*
*5-20-24*
*6-27-24*
*7-25-24*
*8-28-24*
*9-18-24.*

**Plan of Correction** ***Accept ([redacted] - 11/05/2024)***

*We believe this violation should be removed. We believe we are in compliance, as our drills are conducted on varied days of the week and at different times of the day and night, fulfilling the stated requirements. While the regulation does not specifically states different dates of the month, we have had a fire drill on 10/11/24 at 6:10 am. Our November drill is scheduled within the 1st week and December's is scheduled very early the 2nd week. Moving forward, our maintenance manager was made aware of the possibility of receiving this violation while surveyors were present and has taken necessary steps to comply fully. It will be the ongoing responsibility of our maintenance manager to conduct the fire drills as stated in the regulations. [redacted] took immediate action on 10/11/24 and will continue to ensure compliance is met moving forward.*

**Licensee's Proposed Overall Completion Date:** *10/28/2024*

***Implemented ([redacted] - 11/13/2024)***

## 141a - Medical Evaluation

**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.

**Description of Violation**

*Resident # 5 was admitted to the home on [redacted]. The Documentation of Medical Evaluation (DME) form indicated the resident was evaluated on [redacted], more than sixty days prior to the resident's admission to the home.*

*Repeated Violation: 1-30-24 et al.*

**Plan of Correction** ***Accept [redacted] - 11/05/2024)***

*For clarification, the resident did not move into the PC community until [redacted]. [redacted] did, in fact, take possession of her apartment on [redacted]. The resident was evaluated on [redacted] as [redacted] was to move in at that time, however, [redacted]*

## *141a - Medical Evaluation (continued)*

*was moving from independent living and changed [redacted] mind several times. It was an oversight on our part. We do acknowledge that the medical evaluation was more than 60 days prior to her move in. We have completed a new medical evaluation to ensure all her needs are accurately documented. Our admissions and nursing staff have received verbal updated training on the requirements focusing on timely evaluations within the regulatory time frame. Our nursing team will conduct quarterly audits of resident files to ensure adherence to the 60 day medical evaluation requirement for all future admissions. This practice began on 10/9/24 after the preliminary violations were verbalized by the surveyors. It will be the responsibility of the charge nurse to review all paperwork prior to the resident's chart going into the file cabinet. Administrator will spot check for compliance. Quarterly audits will be the responsibility of both the charge nurse and the administrator moving forward and ongoing.*

**Licensee's Proposed Overall Completion Date:** *10/29/2024*

***Implemented ([redacted] - 11/13/2024)***

## 181d -Storing Medication

**13. Requirements**

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

**Description of Violation**

*During the physical site inspection two inhalers were observed in resident # 6's room on a table next to the recliner. The resident was absent from the room and the door to the room was propped open with a wedge, allowing access to unlocked medications.*

**Plan of Correction** ***Accept ([redacted] - 11/05/2024)***

*See Attached. On 10/10/24, the resident was counseled by our charge nurse on the importance of securely locking away medications when he is not present in his room. [redacted] was informed of the potential risks of leaving medications unsecured. The facility has provided all residents who self medicate with a lockbox and resident is aware of how to properly use it. [redacted] also has a key in order to lock and relock as needed. A thorough inspection was conducted on that same day to ensure that all medications are and were locked. The resident stated that he uses [redacted] inhalers more frequently and placed them there for convenience. [redacted] fully understands the self medicating policy and assured the nurse [redacted] will keep medication locked when [redacted] is not in [redacted] room. Staff have been in-serviced on this regulation on 10/10 {and ongoing in order to capture all staff} 10/15 and 10/16. To ensure compliance staff will check the residents room daily on all shifts and during care. We will document if non compliant and Administrator reviewed the self medicating policy and procedure with the resident on 10/10/24. The individual quarterly self medicating assessment form was completed in August and resident will be reassessed again in November to determine if he remains capable to self medicate. This regulation will be reviewed and addressed with all residents at the monthly resident council meeting on 11/7/24 by the administrator. Our charge nurse will be responsible to do room rounds daily for those who self medicate to ensure all medication in safely stored and locked in cabinet. This will be ongoing and has started on 10/9/24.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented [redacted] - 11/13/2024)***

## 183e - Storing Medications

**14. Requirements**

## 183e - Storing Medications *(continued)*

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 #7 is prescribed [redacted] at [redacted] daily. The manufacturer directions indicate the insulin is to be used within 28 days of the insulin being opened. The home did not have documentation when the insulin bottle was opened.*

*Repeated Violation: 1-30-24 et al.*

**Plan of Correction** ***Accept [redacted]/05/2024)***

*See attached. The staff had been in-serviced on 10/10, 10/15/ and 10/16 and reminded of the importance of documenting the date when any medication is opened. The insulin pen in question was immediately removed and discarded and replaced with a new pen dated 10/9/24. A complete cart audit was performed on 10/9/24 by our dayshift Med Tech and no other medications were found to be out of compliance. The facilities' medication administration policy has been reviewed with staff by our staff development coordinator---see attached. All staff have been reminded to to use our double check system which is to check medication carts on each shift and look at each medication which requires an open and expiration date prior to administering. These audits will be completed daily to ensure compliance. Any discrepancies will be corrected immediately and staff involved will receive additional training from staff development. Medication audits will also be conducted by the nurse on shift weekly. She will spot check to ensure efficiency. Staff have been retrained on proper medication documentation practices by Staff development who will additionally train quarterly to reinforce this practice. It is the medication technicians responsibility to ensure compliance as well as inform the nurse when medication is not properly dated or labeled. The nurse will re educate as necessary and Staff development will do quarterly medication in services as an ongoing solution to this regulation.*

**Licensee's Proposed Overall Completion Date:** *10/24/2024*

***Implemented ([redacted] - 11/13/2024)***

## 225a - Assessment 15 Days

**15. 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 # 5 was admitted to the home on [redacted]. The home did not complete an initial assessment of the resident within 15 days of admission. The resident's support plan completion date was [redacted].*

**Plan of Correction** ***Accept [redacted] - 11/05/2024)***

*See attached. We believe this violation should be removed. We appreciate the state's commitment to be thorough, but we're confident that our initial assessment aligns fully with the regulations. Attached please see what we provided to clarify and ensure compliance. The residents chart had been rechecked and the resident did, in fact, take possession of [redacted] PC apartment on [redacted] while still living in out Independent Living Community---The Terrace.*

*225a - Assessment 15 Days (continued)*

*This means [redacted] was paying additionally for the apartment [redacted] was moving to when ready. [redacted] move in was held up due to needing family assistance to help [redacted]. [redacted] physically moved into [redacted] apartment in PC [redacted] on [redacted] Please see active orders signed by physician dated [redacted]. The residents support plan is within the 15 days of admission. Our social worker is responsible for the ongoing compliance as she uses a calendar as her tickler system. Our double check system is our charge nurse who reviews before paperwork goes into the chart and filed. We believe our record is correct.*

**Licensee's Proposed Overall Completion Date:** *10/28/2024*

***Implemented [redacted] - 11/13/2024)***