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

December 24, 2024

PHOEBE RICHLAND HEALTH CARE CENTER

RE: MEADOW GLEN AT PHOEBE RICHLAND
108 SOUTH MAIN STREET
RICHLANDTOWN, PA, 18955
LICENSE/COC#: 14225

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/16/2024, 10/17/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MEADOW GLEN AT PHOEBE RICHLAND* **License #**: *14225* **License Expiration**: *02/08/2025*

Address:

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: *Amanda Laporte* **Phone**: *2673714525* **Email**: *alaporte@phoebe.org*

Legal Entity

Name: *PHOEBE RICHLAND HEALTH CARE CENTER*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/30/2015* **Issued By**: *Richland Burough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *106* **Waking Staff**: *80*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/17/2024*

Inspection Dates and Department Representative

10/16/2024 - On-Site:

10/17/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SCDU* **Capacity**: *40* **Residents Served**: *32*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*

Diagnosed with Mental Illness: *26* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *36* **Have Physical Disability**: *3*

Inspections / Reviews

10/16/2024 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/17/2024*

11/19/2024 - POC Submission

Submitted By: **Date Submitted**: *12/18/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/24/2024*

Inspections / Reviews *(continued)*

11/19/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/18/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/19/2024*

12/24/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/18/2024*

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

65e - 12 Hours Annual Training

2. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A received only 1.75 hours of annual training in training year 2023.

Plan of Correction ***Accept ██ - 11/19/2024)***

Direct care staff person A has been contacted by the PCHA and advised that their mandatory training requirements for 2024 and thereafter must be completed annually. Other Pool team members will be contacted by the PCHA / designee and advised that their mandatory training requirements for 2024 and thereafter must be completed annually. Audits will be completed on a quarterly basis by PCHA / designee to ensure team members are completing their mandatory training requirements as assigned with appropriate follow-up to be completed. Results will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 12/19/2024

Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented ██ - 12/24/2024)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques during training year 2023.

Plan of Correction ***Accept ██ - 11/19/2024)***

Direct care staff person A has been contacted by the PCHA and advised that their mandatory training requirements for 2024 and thereafter must be completed annually. Other Pool team members will be contacted by the PCHA /

65f - Training Topics (continued)

designee and advised that their mandatory training requirements for 2024 and thereafter must be completed annually. Audits will be completed on a quarterly basis by PCHA / designee to ensure team members are completing their mandatory training requirements as assigned with appropriate follow-up to be completed. Results will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
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Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented ███ - 12/24/2024)

65g - Annual Training Content

4. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year 2023.

Plan of Correction ***Accept ███ - 11/19/2024)***

Direct care staff person A has been contacted by the PCHA and advised that their mandatory training requirements for 2024 and thereafter must be completed annually. Other Pool team members will be contacted by the PCHA / designee and advised that their mandatory training requirements for 2024 and thereafter must be completed annually. Audits will be completed on a quarterly basis by PCHA / designee to ensure team members are completing their mandatory training requirements as assigned with appropriate follow-up to be completed. Results will be reviewed by the PCHA at the QA Committee.

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Implemented ███ 12/24/2024)

81b - Resident Personal Equipment

5. Requirements

2600.

81b - Resident Personal Equipment *(continued)*

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

On [redacted] Resident [redacted] has a bedside mobility device that measures 13" wide x 20" high. The device is not secured to the bed frame.

Plan of Correction ***Accept ([redacted] - 11/19/2024)***

Resident [redacted] has had a bedside mobility device secured to the bed frame. An audit has been completed of all bedside mobility devices by PCHA / designee to ensure they are secured to the bed frames. PCHA will send a reminder to residents / family members to notify the PCHA / Nurse Manager when they wish to apply a bedside mobility device to ensure it is attached properly to the bedframe. Nursing team members will be re-educated to notify PCHA / Nurse Manager when a new bedside mobility device has been observed to ensure the device is inspected for proper securement. Random audits of bedside mobility devices for proper securement will be completed monthly x 3 months by PCHA / designee. Results will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 12/19/2024

Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented [redacted] - 12/24/2024)

82c - Locking Poisonous Materials

6. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Sani Cloth disinfectant wipes, with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in Memory Care Wing B nurse station. Not all the residents of the home, including the residents in this area, have been assessed capable of recognizing and using poisons safely.

DG Home Disinfectant Spray, with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in Memory Care Wing B nurse station. Not all the residents of the home, including the residents in this area, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] 11/19/2024)***

Observed sani-cloth disinfectant wipes and disinfectant spray was immediately secured. Nursing and Housekeeping staff will be re-in serviced on the need to secure poisonous materials when attended by PCHA / designee by [redacted] Random audits to ensure poisonous materials are secured when unattended will be completed monthly x3 by PCHA / designee. Results will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 12/19/2024

Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented [redacted] - 12/24/2024)

101j7 - Lighting/Operable Lamp

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident ██ does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ██ - 11/19/2024)***

A source of lighting has been permanently added to the bedside of Resident ██ Room inspections were completed by PCHA / designee to ensure other residents had a source of lighting at bedside. Nursing staff will be reminded that a source of lighting must be at bedside for residents by PCHA / designee. Random audits to ensure there is a source of lighting at bedside for residents will be completed monthly x3 by PCHA / designee. Results will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 12/19/2024

Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented ██ - 12/24/2024)

121a - Unobstructed Egress

8. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On ██████, Memory Care wing A and Memory Care wing B has two doors labeled as "not an exit" however above the doors is an exit sign.

Plan of Correction ***Accept ██ - 11/19/2024)***

The labels on the identified doors were removed. Other exit doors were reviewed by Maintenance for proper exit labeling. Random audits of exit doors for proper labeling will be completed monthly x3 by Maintenance / designee. Results will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 12/19/2024

Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented ██ - 12/24/2024)

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident is prescribed as needed. On , this medication was not available in the home.

On at 5:42 am, Resident reading was however it was not documented on the Medication administration record.

Plan of Correction ***Accept - 11/19/2024)***

Licensed Nurses and Med Techs will be re-educated by PCHA / designee on ensuring ordered medications are available in the facility and the corresponding procedure for notification when medications are needed to be refilled by An audit was completed by Nurse Manager / designee to ensure all ordered medications were available in the facility with follow-up completed, as applicable. Random audits of medications being available in the facility will be completed monthly x3 by Nurse Manager / designee. Licensed Nurses and Med Techs will be re-educated on proper documentation associated with glucometer readings by PCHA / designee. Random audits of documentation associated with glucometer readings will be completed monthly x3 by Nurse Manager / designee. Results of both audits will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 12/19/2024

Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented 12/24/2024)

227d - Support Plan Medical/Dental

10. 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

The assessment for resident , dated , does not indicate the resident has a need for an enabler. The resident's support plan, dated does not document the following:
The resident’s support plan must reflect:
o The specific need for the device
o The intended use and any risks associated with the use
o The resident’s ability to use the device safely for the purpose it was intended

The assessment for resident , dated , does not indicate the resident has a need for an enabler. The resident's support plan, dated does not document the following:
The resident’s support plan must reflect:
o The specific need for the device
o The intended use and any risks associated with the use
o The resident’s ability to use the device safely for the purpose it was intended

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

Plan of Correction ***Accept█ - 11/19/2024)***

Resident █ and █ assessment and support plan has been updated to reflect the need for an enabler and the required components have been added to the support plan by Nurse Manager / designee. Licensed Nurses will be re-educated on the need for a resident's assessment to reflect the need for an enabler bar and the required components of the support plan by PCHA / designee by █. Random audits of residents who are utilizing enabler bars will be completed to ensure the need is documented on the assessment and the support plan reflects the required components will be completed monthly x3 by Nurse Manager / designee. Results of both audits will be reviewed by the PCHA at the QA Committee.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 12/19/2024

Licensee's Proposed Overall Completion Date: *12/19/2024*

Implemented █ - 12/24/2024)