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

December 12, 2024

[redacted]
ASBURY ATLANTIC
[redacted]

RE: BETHANY VILLAGE RETIREMENT CENTER
5225 WILSON LANE
MECHANICSBURG, PA, 17055
LICENSE/COC#: 33023

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/29/2024, 10/30/2024 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: *BETHANY VILLAGE RETIREMENT CENTER* **License #**: *33023* **License Expiration**: *06/27/2025*

Address: *5225 WILSON LANE, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *ASBURY ATLANTIC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/27/2005* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *130* **Waking Staff**: *98*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/30/2024*

Inspection Dates and Department Representative

10/29/2024 - On-Site: [redacted]

10/30/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *100*

Special Care Unit

In Home: *Yes* **Area**: *Goldenmaple* **Capacity**: *30* **Residents Served**: *30*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *100*

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

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

Inspections / Reviews

10/29/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/22/2024*

Inspections / Reviews *(continued)*

11/25/2024 POC Submission

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

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *12/02/2024*

12/02/2024 POC Submission

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

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/13/2024*

12/12/2024 Document Submission

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

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

18 Other laws, regs, ordins.

1. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

As per the Care Facility Carbon Monoxide Alarm Standards Act, batteries must be replaced at least one annually and must be installed no less than 15 feet from any fossil-fuel burning device or appliance. The carbon monoxide detector, plugged into the wall in the residence's main kitchen, has a battery installation date of [redacted]. Additionally, the carbon monoxide detector was plugged in the wall, approximately 1 foot from the residence's fossil fuel burning stove.

Plan of Correction ***Directed [redacted] - 12/02/2024)***

On [redacted] Dining Director immediately replaced the battery. Dining Director and Director of Facilities met to develop a plan. Plan is attached.
On [redacted] Administrator educated Dining Director and Director of Facilities regarding the requirement to change batteries annually and the required distance between the Carbon Monoxide Alarm and any fossil-fuel burning devices. Director of facilities confirmed the alarm had been moved at least 15ft from any fossil-fuel burning devices on [redacted] Director of Facilities will monitor the annual battery changes.

(Directed)

- *In addition to the above plan of correction, regular battery changes will be completed at least annually. As of [redacted], an automatic alert message was entered into the work order system for an annual reminder to change the battery.*

Directed Completion Date: *12/02/2024*

Implemented [redacted] 12/12/2024)

25b Contract signatures and renewal

2. Requirements

2800.
25b . The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident [redacted] and their payee did not sign and date the [redacted] resident-residence contract.

Repeated Violation - 12/12/23, et al.

Plan of Correction ***Accept ([redacted] - 11/25/2024)***

[redacted] Resident was given the opportunity to review and sign the contract. Contract was signed on [redacted] by resident. On [redacted] Sales Associate was instructed to complete contract audits on both second and third floor, this audit will be completed by [redacted] Weekly chart reviews on Mondays continue for all new admissions. Weekly chart reviews are completed by [redacted] Administrator and [redacted] Sales Director.

25b Contract signatures and renewal *(continued)*

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

Implemented (12/12/2024)

65i Training topics

3. Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.

Description of Violation

Direct Care Staff Member C did not receive training in medication self administration during the 2023 training year.

Plan of Correction ***Accept 11/25/2024)***

2023 Relias course completion was audited by Administrator, for all associates. There were no incomplete courses found during this audit. Administrator spoke directly to all Direct Care Staff Members, instructing all 2024 courses be completed by or staff will be removed from the schedule to allow for completion. Administrator and Clinical Scheduler will audit 2024 course completed on . Moving forward course completion audits will be completed each year by Administrator and Clinical Scheduler.

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

Implemented 12/12/2024)

107d Procedure EMA submission

7. Requirements

2800.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been sent to the local emergency management agency annually as confirmed by Staff Member A.

Plan of Correction ***Accept 12/02/2024)***

Emergency procedures were mailed to local emergency management agency on Administrator and Facilities Director review annually. Moving forward the Emergency Management procedures will be mailed annually. On Administrator educated Director of Facilities regarding the requirement to annually submit Emergency Procedure plan to the local emergency management agency after the annual review is completed by Admin and Dir of Facilities. Administrator has placed a annually repeating calendar invite for February, Admin will mail required information annually after annual review with Dir of Facilities.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented - 12/12/2024)

141a Medical evaluation

8. Requirements

2800.
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:
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

Description of Violation

Resident [redacted], admitted to the residence on [redacted], did not receive a [redacted] or [redacted] with [redacted] results within the previous two years. According to their initial medical evaluation, dated [redacted] they last received a [redacted] " on [redacted] with [redacted] results.

The initial medical evaluation for Resident [redacted], dated [redacted], does not include the results of their [redacted] or [redacted]. This area of the form is blank.

The initial medical evaluation for Resident [redacted] dated [redacted], does not include the results of their [redacted] or [redacted] This area of the form is blank, and at the time of the [redacted] inspection, the residence did not have records of the results.

Resident [redacted], admitted to the residence on [redacted], did not receive a [redacted] or [redacted] with [redacted] results within the previous two years. According to their initial medical evaluation, dated [redacted], they last received a [redacted] skin test on [redacted]

Plan of Correction ***Accept [redacted] 12/02/2024)***

[redacted] Administrator verified by record review that all [redacted] residents listed did in fact receive [redacted] testing.
[redacted] Administrator provided education to licensed staff on [redacted] at a mandatory staffing meeting that indicated current (within 2 yrs) [redacted] documentation must be placed on the [redacted]
Chart reviews are completed every Monday at 1pm by [redacted] Administrator, [redacted] Sales Director, Licensed staff on duty. [redacted] documentation during chart reviews began on 11/4/24. TB documentation on the ADME will be assessed during the chart reviews on Mondays and updates/changes will be made at that time by Licensed Staff. New admissions and 2 additional charts from each floor are reviewed during the Monday meetings.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 12/12/2024)

141b1 Annual medical evaluation

9. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident [redacted] annual medical evaluation, dated [redacted] did not include the results of their [redacted] completed on [redacted] and [redacted]

Resident [redacted] annual medication evaluation, dated [redacted] did not include the results of their most recent

141b1 Annual medical evaluation (continued)

[redacted] or [redacted], or the date either test was completed.

Plan of Correction ***Accept [redacted] - 12/02/2024)***

Resident [redacted] annual medical evaluation was update on [redacted] by LPN to reflect test results for [redacted] completed [redacted] and [redacted]
Resident [redacted], annual medical evaluation was update [redacted] by LPN to reflect test results for [redacted] completed on [redacted] and [redacted]
[redacted] Administrator held all licensed staff meeting on [redacted]. All licensed staff were educated on the requirement to place [redacted] results on the annual [redacted] Administrator, [redacted] Sales, Licensed Staff on duty, meet each Monday to complete chart reviews. Moving forward proper [redacted] Documentation on annual [redacted] will be assessed at these Monday meetings.
[redacted] documentation/chart reviews began on [redacted] New admissions and 2 charts from each floor are reviewed at the weekly meeting.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 12/12/2024)

183b Medications and syringes locked

10. Requirements

2800.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

On [redacted], at 12:38PM, Resident [redacted] was unlocked, unattended, and accessible on a stand next to their recliner, in their bedroom. Resident [redacted] is not assessed to be able to self-administer the medication, nor was the resident present in their bedroom, and their bedroom door was unlocked.

On [redacted], at approximately 4:30PM, Staff Member E was witnessed leaving the 2nd floor medication cart, housing numerous residents' medications, unlocked, accessible, and unattended sitting in the 2nd floor hallway.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

On [redacted] Licensed staff removed the nasal spray from resident [redacted] apartment. Resident and POA indicated the medication was from years ago and POA suggested it was accidently dropped in [redacted] apartment during a visit the evening prior. No other medication/prescriptions were found in the apartment.
On [redacted] [redacted] Administrator provided education to the licensed staff regarding meds being locked/stored properly and the requirement to have a physician's order to self-administer.
Licensed staff are identifying residents that self-administer medications and are entering a nursing order on the MAR indicating that medications, OTC, CAM and syringes are kept in a locked area. This order will show for each shift to sign off on. This will be completed by 12/2/24
AL Administrator provided education regarding securing medications at the [redacted] licensed staff training. Cart audits will be completed monthly by Albright Pharmacy and securing carts will be addressed at that time.

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

Implemented [redacted] - 12/12/2024)

183e Storing Medications

11. Requirements

2800.
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 [redacted] is prescribed insulin aspart. The medication label indicated the medication was opened on [redacted] and is expired in 28 days. However, the expired [redacted] aspart was administered to Resident [redacted] at 7:30AM and 11:30AM on [redacted].

Plan of Correction ***Accept [redacted] 12/02/2024)***

On [redacted] Licensed staff discarded the [redacted] A cart audit was completed, no additional expired medication was discovered. POA/PCP/Resident were notified of the error. No new orders r/t the error.
On [redacted] Albright Clinical Pharmacy Director completed a cart audit. No expired medication was discovered. Monthly cart audits will be completed by Albright Clinical Pharmacy Director.
Daily checklist, for nightshift Licensed Staff, have been posted/provided to the Licensed Staff, indicating daily checks be completed to include documented checks that all medication changes be indicated with a "Direction Change" sticker as provided by Albright Pharmacy. Licensed staff will turn the checklists in to the DON.
On [redacted] all LPN's were provided education regarding the discarding of insulin per manufacturers recommendations. This education was provided at a mandatory staff meeting and education was provided by [redacted] Administrator and Albright Clinical Pharmacy Director.
Monthly cart audits completed by Albright Clinical Pharmacy Director began on [redacted] and will be completed monthly.
On [redacted] Licensed staff on 11pm-7am were provided nightly checklists that includes assessing expiration dates on insulin pens.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 12/12/2024)

184a Resident meds labeled

12. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Since [redacted], Resident [redacted] is prescribed [redacted] at bedtime, [redacted] at 8PM, and [redacted] at 8PM. However, the medication labels for [redacted], and [redacted] all indicate to administer the medication at 5PM.

As of [redacted], Resident [redacted] is prescribed [redacted], [redacted] subcutaneously one time a day and [redacted] subcutaneously at bedtime, can increase dose by 2 units every 3 days for blood sugar trending higher than 15, max dose 62 units. The pharmacy label for Resident [redacted] does not include their current order, but reads, [redacted] in the morning and [redacted] at bedtime, increase by 2 units every 3 days for glucose greater than 150, max dose 62 units, hold for blood glucose greater than 70.

On [redacted] Resident [redacted] physician updated the resident's [redacted] orders to read, [redacted] subcutaneously 2 times a day for diabetes mellitus with breakfast and supper, hold for blood sugar less than 120, and

184a Resident meds labeled (continued)

also has a sliding scale prescribed dose. However, on [redacted], the medication label for Resident [redacted] read, [redacted] subcutaneously 3 times daily, and 4 times daily per sliding scale, hold for blood glucose greater than 90.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

On [redacted] Licensed staff phoned Albright pharmacy requesting the administration time be changed for resident [redacted] medications [redacted], and [redacted].
[redacted] Administrator discussed the finding with PCC contact and discovered a way that Licensed staff could request a time change at the time of discovery. Education regarding this new process was discussed at the [redacted] Licensed staff meeting. On [redacted] cart audits were completed by Albright Clinical Pharmacy Director; no other medication packs were found to have the wrong time. Monthly cart audits by Albright Clinical Pharmacy Director will continue. On [redacted] [redacted] labels for resident [redacted]4 were updated with direction change stickers. Al[redacted] were audited, and no others were found with incorrect directions. Licensed staff education was provided by Albright Pharmacist and[redacted] Administrator at the [redacted] Licensed staff training. Medication cart audits were completed on [redacted] by Albright Clinical Pharmacy Director and will continue monthly

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

Implemented [redacted] - 12/12/2024)

185a Storage procedures

13. Requirements

2800.
185.a. The residence 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 [redacted] requires full staff assistance with medication management and administration, and obtaining medical services as ordered. On [redacted], Resident [redacted] was prescribed [redacted] subcutaneously one time a day and [redacted] subcutaneously at bedtime, can increase dose by 2 units every three days for blood sugar trending higher than 15, max dose 62 units. From [redacted] until [redacted], Resident [redacted] was prescribed [redacted] in morning and [redacted] at bedtime (increase by 2 units every 3 days for glucose greater than 150 max dose 62 units), hold for blood glucose greater than 70. On [redacted], Staff Member A, Staff Member F, and Staff Member G confirmed the previous and current [redacted] orders for Resident [redacted] are confusing and contradictory, and they would not know how to administer the medication as prescribed. As of [redacted], the residence has not arranged for or assisted the resident to obtain clear administration orders for their [redacted] injection.

Plan of Correction ***Accept [redacted] - 12/02/2024)***

On [redacted] the [redacted] for resident [redacted] were labeled with a direction change sticker by Licensed Staff. Also, Licensed Staff requested new labels from Albright Pharmacy. An audit was completed immediately, and no other insulin pens were found to have incorrect orders. On [redacted] Licensed Staff verified the orders printed on the [redacted] labels were orders received by Albright pharmacy from a recent hospitalization. Such orders would be appropriate in a hospital setting.

185a Storage procedures (continued)

On [redacted] Administrator and Pharmacy Manager provided education at mandatory Licensed Staff meeting regarding the requirement to immediately place a sticker indicating an order change and request a new label from Albright Pharmacy. Cart audits were completed on [redacted] by Clinical Pharmacy Director and no additional insulin pens were found to have incorrect directions. Clinical Pharmacy Director will complete cart audits monthly. Checklists provided to Licensed Staff indicate the need for 11 7am Licensed Staff to verify proper indication of medication order changes be completed during chart checks.
On [redacted] checklists were provided to licensed staff.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 12/12/2024)

187a Medication record

14. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [redacted] is prescribed [redacted] daily for [redacted]. However, Resident [redacted] medication administration record indicates the diagnosis or purpose for the medication is "related to [redacted] due to underlying condition with [redacted] ".

Resident [redacted] is prescribed the following orders for [redacted]. However, resident's [redacted] medication administration record does not include diagnosis or purpose for the medication, including pro re nata (PRN

- *[redacted] by mouth at bedtime*
- *[redacted] by mouth once time a day with breakfast*
- *[redacted] by mouth one time a day with lunch*

Plan of Correction ***Accept [redacted] - 12/02/2024)***

On [redacted] Licensed Staff updated MAR to indicate [redacted] for the [redacted] and [redacted] of [redacted] for the [redacted]. Resident does not receive [redacted] Administrator spoke with [redacted] representative and obtained clarification regarding [redacted] entry in [redacted] which is a new electronic medical record system to [redacted] in 2024. On [redacted] Administrator and Pharmacy Manager provided education to Licensed Staff regarding the entry of [redacted] on the MAR. Licensed Staff will audit MAR/TAR's and will make necessary changes to any [redacted] in [redacted] Licensed Staff were educated on adding [redacted] at the time of medication order entry and the requirement for 11p 7am Licensed Staff to audit during nightly chart checks. [redacted] Administrator provided 11p 7a licensed staff a checklist that also indicates the requirement to check for [redacted] on the MAR.
On [redacted] checklists were provided and started by licensed staff.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented [redacted] - 12/12/2024)

187d Follow prescriber's orders

15. Requirements

2800.

187d Follow prescriber's orders *(continued)*

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

Description of Violation

As of [redacted], Resident [redacted] medications are prescribed to be crushed and administered in applesauce. However, Resident [redacted] reports approximately a week ago, staff provided Resident [redacted] with medication in pill form sitting in applesauce, and Resident [redacted] ingested the medication as is.

Resident [redacted] was not administered their [redacted] at 1400 on [redacted].

Repeated Violation - 12/12/23, et al.

Plan of Correction ***Directed [redacted] 12/02/2024)***

On [redacted] Administrator reviewed residents' orders. Resident receives crushed medication per physician's orders except for medications that cannot be crushed as indicated on the medication pill packs. [redacted] Administrator verified with evening Licensed Staff that resident does receive several pills during the evening medication pass that are not crushed as indicated on the medication pill packs. On [redacted] Administrator and Social Worker spoke with resident [redacted], resident indicated [redacted] does take some medication whole but wasn't sure if the nurse knew what [redacted] was doing because [redacted] was new. Resident was made aware of [redacted] right to question any medication and its form of administration.
On [redacted] Administrator investigated the failure to administer [redacted] for resident [redacted]. [redacted] Administrator spoke with Licensed Staff member working during the failed administration time. Licensed Staff indicated [redacted] remembered giving the medication and fear [redacted] failed to complete the final step of documentation. Licensed Staff was instructed to enter a late entry note indicating the administration of [redacted] at 1400. [redacted] Administrator spoke with the oncoming Licensed Staff member scheduled for the 3pm-11pm shift on [redacted] who verified there were no 1400 medications found in the cart. [redacted] Administrator reeducated Licensed Staff regarding the requirement to complete the 6 steps of safe medication administration. [redacted] Administrator and Albright Pharmacy Manager provided education to Licensed Staff at the team meeting regarding safe medication administration.
On [redacted] at the mandatory staff meeting LPN's were educated regarding the requirement to review documentation at the end of their shift in PCC to ensure all documentation has been completed.

(Directed)
In addition to the above plan of correction, the administrator or designee will complete a weekly audit of at least 5% of resident Medication Administration Records beginning no later than 12/9/24 to ensure medications are administered as directed by a physician.
documentation of completed education an audits will be kept by the home and available for review by the Department.

Directed Completion Date: *12/09/2024*

Implemented [redacted] - 12/12/2024)

224a5 Written initial assessment

17. Requirements

2800.
224.a.5. The written initial assessment must, at a minimum include the following:

224a5 Written initial assessment *(continued)*

ii. The mobility needs of the individual.

Description of Violation

Resident [redacted] utilizes a bedside mobility device to assist with ambulation and movement in and out of bed. Resident [redacted] initial and final assessments, dated [redacted] and [redacted] do not include: the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Directed [redacted] - 12/02/2024)***

Resident [redacted] did not admit to [redacted] with a bed enabler. Resident was assessed on [redacted] for the need of a bed enabler.
On [redacted] Administrator provided education to Rehab Director regarding proper documentation of the enabler device located on the ASP.
On [redacted] Administrator and Rehab Director updated residents' current ASP to include proper documentation.
On [redacted] Administrator and Rehab Director completed an audit of all residents with enabler bars. Currently only one other resident has an enabler bar. On [redacted] Admin and Rehab Director updated this record as well with required documentation.
Rehab Director will begin completing this required documentation.
Attached are the homes documentation created to ensure the new documentation process.

(Directed)
In addition to the above plan of correction, beginning no later than 12/9/24, any resident's who utilize a bedside mobility device will have a Bedside Mobility Device Assessment/Physician Review form completed by the Rehab Director.

Directed Completion Date: *12/09/2024*

Implemented [redacted] - 12/12/2024)