

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

December 4, 2024

[REDACTED]
BERKS LEISURE LIVING INC
[REDACTED]

RE: BERKS LEISURE LIVING
1399 FAIRVIEW DRIVE
LEESPORT, PA, 19533
LICENSE/COC#: 20569

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/05/2024 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: *BERKS LEISURE LIVING* License #: *20569* License Expiration: *03/23/2025*
 Address: *1399 FAIRVIEW DRIVE, LEESPORT, PA 19533*
 County: *BERKS* Region: *NORTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *BERKS LEISURE LIVING INC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *01/04/2000* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *40* Waking Staff: *30*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *11/05/2024*

Inspection Dates and Department Representative

11/05/2024 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *49* Residents Served: *39*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *2*

Number of Residents Who:
 Receive Supplemental Security Income: *12* Are 60 Years of Age or Older: *38*
 Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *2*
 Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

11/05/2024 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/23/2024*

11/25/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *12/03/2024*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *11/30/2024*

Inspections / Reviews *(continued)*

12/02/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/03/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/06/2024

12/04/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/03/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] staff person A was overheard yelling loudly at resident [redacted] by staff person B. Staff person A was heard threatening resident [redacted] to "knock it off" or they would be "sent to the hospital". Staff person B did not report the incident to the administrator until [redacted] and the home did not send a report to the Area Agency on Aging until [redacted].

Plan of Correction

Accept [redacted] - 11/25/2024)

Violation of 2600.15.a. occurred when staff person "B" failed to immediately make Administrator aware of the incident of staff person "A" yelling at resident [redacted] when it occurred [redacted]. Administrator failed to make an immediate report [redacted] once made aware having waited on a supporting written report by staff person "B" [redacted]. The requirements regarding restrictions regarding staff person "A" were not adequately followed [redacted] when staff person "A" was removed from the care of resident [redacted] by staff person "B" for the completion of shift [redacted] and following the date of entire shift on [redacted]. Staff person "A" was suspended of duty [redacted] until results of investigation were completed.

ALL current staff have been re-educated on importance of reg 2600.15.a. and are required to acknowledge additional training/education through signed documentation of educational material which will be kept in their individual employee files. All new hires will also receive additional training on reg 2600.15.a. and will be required to acknowledge the training through signed and dated material which be kept as part of the hiring/training process in their employee file. Annual training related to communication with residents diagnosis with dementia will be conducted 11/29/24.

Training will be conducted by Administrator [redacted] staff LPN [redacted] and/or area on Aging Protective Services representative. General manager [redacted] will audit employee files for regulatory trainings

Licensee's Proposed Overall Completion Date: 11/29/2024

Implemented [redacted] - 12/04/2024)

15b - Supervisor Plan

2. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted] at approximately 7pm staff person A was overheard yelling loudly at resident [redacted] by staff person B. Staff person A was heard threatening resident [redacted] to "knock it off" or they would be "sent to the hospital". Staff person B reported the incident to the administrator on [redacted] and provided a written statement on [redacted]. Staff person A was not immediately suspended on [redacted] when the administrator received the report of suspected abuse. Staff person A continued to work the remainder of their shift on [redacted] and also worked on [redacted] from 3pm to 11pm. Staff person A was not under any type of direct supervision while performing direct care to residents on [redacted]

Plan of Correction

Accept [redacted] - 11/25/2024)

Violation of 2600.15.b. occurred when the requirements of supervision/suspension were not adequately followed.

15b Supervisor Plan (continued)

Staff person "A" was removed from the care of resident [redacted] by staff person "B" on [redacted] when staff person "A" was overheard to be yelling at resident [redacted] at approximately 7pm by staff person "B". Staff person "A" did not provide care to resident [redacted] during the remainder of shift nor on next assigned day [redacted] and was suspended from work [redacted] pending results of investigation of reported alleged abuse. This did not meet the requirements of an immediate plan of supervision or suspension of staff person "A" on [redacted] when the alleged abuse took place. ALL current staff and "new hires" will be additionally educated and will receive related materials on the requirements necessary to meet reg 2600.15.b. should such an allegation of abuse occur. Copies of the signed materials acknowledging education will be kept in all current staff and new hires as they occur. Administrator [redacted]; staff LPN [redacted] will conduct trainings. General manager [redacted] will audit employee files for completion of regulatory trainings.

Licensee's Proposed Overall Completion Date: 11/29/2024

Implemented [redacted] - 12/04/2024)

42b - Abuse

3. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at approximately 7pm staff person A was overheard by staff person B yelling loudly at resident [redacted] Staff person B reported staff person A screamed "You better knock it off or I'm going to send you to the hospital" to resident [redacted] Staff person B also reported that resident [redacted] began crying upon hearing this stating "No, I don't want to go to the hospital". Resident [redacted] had been experiencing an increase in anxious behaviors due to declining health status and was verbally abused and intimidated by staff person A.

Plan of Correction

Accept [redacted] - 11/25/2024)

Violation of reg 2600.42.b. occurred when staff person "A" loudly yelled at resident [redacted] and threatened to send [redacted] to the hospital, causing resident [redacted] to cry.

Staff person "A" was suspended and has since been terminated as the results of the investigations.

ALL staff are educated on reg 2600.42.b. as part of Resident Rights on hire and annually. At this time, re education has occurred for current staff with additional training for new hires as they occur. Staff will also receive additional training on communication with residents with alzheimers disease/dementia.

Administrator [redacted] staff LPN [redacted] will conduct trainings. General Manager [redacted] will review employee files for regulatory trainings.

Licensee's Proposed Overall Completion Date: 11/29/2024

Implemented [redacted] - 12/04/2024)