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

March 31, 2025

REGIONAL OPERATIONS SPECIALIST
DOUGLASSVILLE AID II OPCO LLC

RE: AMITY PLACE
139 OLD SWEDE ROAD
DOUGLASSVILLE, PA, 19518
LICENSE/COC#: 22656

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/03/2024, 12/12/2024 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: *AMITY PLACE* **License #:** *22656* **License Expiration:** *10/18/2024*

Address: *139 OLD SWEDE ROAD, DOUGLASSVILLE, PA 19518*

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

Administrator

Name: **Phone:** **Email:**

Legal Entity

Name: *DOUGLASSVILLE AID II OPCO LLC*
Address:
Phone: **Email:**

Certificate(s) of Occupancy

Type: *I-1* **Date:** *02/12/2009* **Issued By:** *Amity Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *70* **Waking Staff:** *53*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *12/12/2024*

Inspection Dates and Department Representative

12/03/2024 - On-Site:
12/12/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *44*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *44*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *26* **Have Physical Disability:** *0*

Inspections / Reviews

12/03/2024 - Full

Lead Inspector: **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/16/2025*

01/22/2025 - POC Submission

Submitted By: **Date Submitted:** *01/16/2025*

Reviewer: **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/29/2025*

Inspections / Reviews *(continued)*

02/12/2025 - POC Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *01/30/2025*

Follow-Up Type: *Bypass Document Submission*

03/31/2025 - Bypass Document Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *02/12/2025*

Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

The home failed to report an allegation of abuse to the Licensing Department. The allegation of abuse involved resident #1 and an unknown assailant. The incident allegedly occurred on 6/9/24, during a church service and in the residents' bedroom.

Plan of Correction ***Accept (█ - 01/22/2025)***

1. Executive Director (ED) and Resident Wellness Director (RWD) of the time of incident are no longer employed at Amity Place
2. On 12/20/2024 - Current ED and RWD re-educated on Regulations 16c and 15 by Regional Operations Specialist (Exhibit 1)
3. By 2/8/2025 – Current Staff will be re-educated on Abuse Reporting (Exhibit 2)
4. Starting 1/20/2025 – ED or Designee will interview 3 random Residents weekly x 4 weeks asking if they have been treated in a disrespectful or undignified manner by a staff member (Exhibit 3)
5. By 1/31/2025 - Family Satisfaction Survey sent via email to POA/Emergency Contact of Current Residents (Exhibit 4)
6. ED or Designee will monitor to ensure ongoing compliance

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

Implemented (█ - 02/27/2025)

29a SOPb1- Hospice Care: Doctor Certification

2. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

Staff indicated that resident #2 and #3, were not evacuated during the fire drills conducted from 6/26/24 to 11/25/24 because they are actively dying and on hospice. There is no written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

Plan of Correction ***Accept (█ - 01/22/2025)***

1. ED and RWD of the timeframe are no longer employed by Amity Place
2. On 12/20/2024 – Current ED, RWD and Maintenance Director re-educated on Regulation 29.a.b. by Regional Director of Wellness Services (Exhibit 5)
3. By 2/8/2025 – Current Staff will be re-educated on Regulation 29.a.b. (Exhibit 6)
4. Starting 1/20/2025 – RWD or Designee will review Residents on caseload with Hospice Service Providers x 4 weeks and if deemed to be actively dying, documentation will be requested from physician regarding appropriateness for participation in fire drills. (Exhibit 7)

29a SOPb1- Hospice Care: Doctor Certification (continued)

5. RWD or Designee will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

During a fire emergency, the home is allowed two minutes and 30 seconds to evacuate residents from the building or to an internal fire safe area. The home has a census of 44 residents, with 26 individuals requiring assistance to evacuate. Additionally, six of the residents utilize a Hoyer lift for transfers, requiring the assistance of two staff members. On 11/30/2024 and 12/1/2024 the home did not have sufficient overnight staffing needed to evacuate all residents. On each of these nights there were two staff members working, from 10:30pm – 6:00am.

Plan of Correction ***Accept (█ - 01/30/2025)***

1. On 12/23/2024 - Current ED and Maintenance Director re-educated on Regulation 60.a by Regional Director of Facilities Management (Exhibit 8)
2. By 2/15/2025 – Updated Fire Evacuation Letter will be obtained from assessing Fire Safety Expert (Exhibit 9)
3. Until updated letter is obtained, ED and RWD will review care and ancillary staff schedules weekly to meet the evacuation needs for default evacuation time of 2.5 minutes.
4. Maintenance Director will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

65f - Training Topics

4. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
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.

Description of Violation

Staff Member A did not complete trainings in the required topics of instructions on meeting the needs of the residents and infection control during the 2023 training year. Staff Member B did not complete training in topic of instructions on meeting the needs of the residents for the 2023 training year.

65f - Training Topics (continued)

Repeat Violation: 11/7/23

Plan of Correction ***Accept (█ - 01/22/2025)***

1. On 12/20/2025 – RWD re-educated on Regulation 65.f by Regional Director of Wellness Services (Exhibit 10)

2. By 1/31/2025 - Staff A and B will complete listed Educations/Trainings (Exhibit 11)

3. By 1/31/2025 – ED will verify all required annual training topics are included in the 2025 Training Plan (Exhibit 12)

4. Starting 1/27/2025 – Business Office Manager (BOM) will audit Training Plan monthly for current staff training compliance (Exhibit 13)

5. BOM or Designee will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

65g - Annual Training Content

5. 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:

5. Falls and accident prevention.

Description of Violation

Staff Member B did not complete training in falls and accident prevention for the 2023 training year.

Plan of Correction ***Accept (█ - 01/22/2025)***

1. On 12/20/2025 – RWD re-educated on Regulation 65.f by Regional Director of Wellness Services (Exhibit 10)

2. By 1/31/2025 - Staff A and B will complete listed Educations/Trainings (Exhibit 11)

3. By 1/31/2025 – ED will verify all required annual training topics are included in the 2025 Training Plan (Exhibit 12)

4. Starting 1/27/2025 – Business Office Manager (BOM) will audit Training Plan monthly for current staff training compliance (Exhibit 13)

5. BOM or Designee will monitor for ongoing compliance

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

Implemented (█ - 03/31/2025)

109b - Rabies Vaccination

6. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

The home did not have a current rabies vaccination on file for two house cats by the names of Elizabeth Taylor and

109b - Rabies Vaccination (continued)

Grace Kelly.

Repeat Violation: 11/7/23

Plan of Correction ***Accept (- 01/22/2025)***

1. 1/8/2025 - Rabies vaccination completed for Elizabeth Taylor and Grace Kelly via DVM (mobile veterinarian) (Exhibit 16)
2. On 12/20/2024 - Current ED, RWD and RCD re-educated on Regulation 109b by Regional Operations Specialist (Exhibit 17)
3. Starting 1/27/2025 – Pet vaccination records will be audited monthly to ensure rabies vaccinations are current (Exhibit 18)
4. ED or Designee will monitor for ongoing compliance

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

Implemented (- 02/27/2025)

129a - Fireplace Screens

7. Requirements

2600.
129.a. A fireplace must be securely screened or equipped with protective guards while in use.

Description of Violation

The home has two gas fireplaces that emit heat while in operation. Neither fireplace contains a protective guard to ensure residents can not touch the unit. The home has a census of 44 residents and serves individuals with a diagnosis of dementia. During 12/3/2024 onsite inspection, one fireplace was in use and the metal framing, encompassing the fireplace insert, was hot to the touch.

Plan of Correction ***Accept (- 01/22/2025)***

1. On 12/12/2024 - Fireplace screens were put into place for all 3 gas fireplaces (Exhibit 19)
2. On 12/23/2024 - ED and Maintenance Director re-educated on Regulation 129.a by Regional Director of Facilities Management (Exhibit 20)
3. By 1/27/2025 – Preventative Measure entered into TELS for weekly check fireplace screens remain in place. (Exhibit 21)
4. Maintenance Director or Designee will monitor for continued compliance

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

Implemented (- 02/27/2025)

132c - Fire Drill Records

8. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

132c - Fire Drill Records *(continued)*

Description of Violation

Fire drill records from 2/16/24 through 11/25/24, do not indicate which exits were used during each drill.

Plan of Correction ***Accept (█ - 01/22/2025)***

1. 12/12/2024 - Maintenance Director re-educated on Regulation 132.c by ED (Exhibit 22)

2. 12/31/2024 – Fire Drill conducted and recorded in compliance with Regulation 132.c (Exhibit 23)

3. ED or Designee will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

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

Beginning in May 2024, the home did not have a written letter within the last year from a fire safety expert giving the home an extended evacuation time. Without this letter the home's maximum allowed evacuation time is 2 minutes and 30 seconds. Each fire drill completed from 5/2024 through 11/2024 was completed in over 2 minutes and 30 seconds.

Plan of Correction ***Accept (█ - 01/30/2025)***

1. On 12/23/2024 - Current ED and Maintenance Director re-educated on Regulation 132.d by Regional Director of Facilities Management (Exhibit 24)

2. By 2/15/2025 – Updated Fire Evacuation Letter will be obtained from assessing Fire Safety Expert (Exhibit 9)

3. Until updated letter is obtained, ED and RWD will review care and ancillary staff schedules weekly to meet the evacuation needs for default evacuation time of 2.5 minutes.

4. Maintenance Director will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

132h - Designated Meeting Place

10. 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.

132h - Designated Meeting Place *(continued)*

Description of Violation

Fire drill records indicate that resident #2 and #3, were not evacuated during the fire drills conducted from 6/26/24 to 11/25/24. There is no written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

Plan of Correction ***Accept (█ - 01/30/2025)***

1. ED and RWD of the timeframe are no longer employed by Amity Place
2. On 12/20/2024 – Current ED, RWD and Maintenance Director re-educated on Regulation 132.h by Regional Director of Wellness Services (Exhibit 25)
3. As of 12/21/24, Residents 2 and 3 are participating in evacuation drills.
4. By 2/8/2025 – Current Staff will be re-educated on Regulation 132.h (Exhibit 26)
5. Starting 1/20/2025 – RWD or Designee will review Residents on caseload with Hospice Service Providers x 4 weeks and if deemed to be actively dying, documentation will be requested from physician regarding appropriateness for participation in fire drills.
6. (Exhibit 27)
7. RWD will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

133.2 - Exit Signs Direction

11. Requirements

2600.
133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

The home has a large dining room that can be accessed from an adjacent common area, through two sets of double fire doors. This dining room serves as an egress route in case of emergencies and is equipped with two exits. In the event of a fire drill, the wall-mounted magnetic door holders are released, automatically closing all fire doors. However, it was observed during the onsite inspection on 12/3/2024 that the area's leading into or out of the dining room lacked exit signs to clearly mark the available exits beyond the double doors.

Plan of Correction ***Accept (█ - 01/22/2025)***

1. 12/12/2024 - Exit Signs put into place prior to Survey Exit Meeting (Exhibit 28)
2. 12/12/2024 – Maintenance Director re-educated by ED on Regulation 133.2 (Exhibit 29)
3. By 1/27/2025 – Preventative Measure entered into TELS for weekly check Exit Signs remain in place. (Exhibit 30)
4. Maintenance Director or Designee will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

162c - Menus Posted

12. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 12/3/24 at approximately 10:00am, the menu for the month of November 2024 was still posted in the home and there was no menu posted for the current week or 1 week in advance as required.

Plan of Correction ***Accept (- 01/22/2025)***

1. 12/3/2024 – Menu updated for December 2024 by Food Service Director
2. 1/1/2025 – Menu updated for January 2025 by Food Service Director (Exhibit 31)
3. 12/12/2024 – Food Service Director re-educated by ED on Regulation 162.c (Exhibit 32)
4. ED or Designee will monitor for ongoing compliance

Licensee's Proposed Overall Completion Date: *03/01/2025*

Implemented (- 02/27/2025)

183b - Meds and Syringes Locked

13. Requirements

2600.
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 room.

Description of Violation

On 12/12/24, at 1:15pm, Anbesol max strength gel and Desitin max strength paste was unlocked, unattended and assessable in resident #4’s room.

Plan of Correction ***Accept (- 01/22/2025)***

1. 12/3/2024 - Listed OTC medications removed from room and stored into med cart by RCC
2. 12/20/2025 – RWD re-educated on Regulation 183.b by Regional Director of Wellness Services (Exhibit 33)
3. By 2/8/2025 – Current Med Administrating Staff by RWD re-educated on Regulation 183.b
(Exhibit 34)
4. Starting 1/20/2025 – RWD or designee will audit 3 random Resident rooms weekly to verify no medications are improperly stored x 4 weeks (Exhibit 35)
5. RWD or Designee will monitor for ongoing compliance

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

Implemented (- 02/27/2025)

184b - Labeling OTC/CAM

14. Requirements

2600.

184b - Labeling OTC/CAM *(continued)*

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

During medication cart audit on 12/12/24, at 1:15pm, medications were in the cart that were not labeled with a name. The following medications were in Cart 2 but not labeled with a resident name: Cranberry 4200mg, D3, and Centrum Woman 50+.

Plan of Correction ***Accept (- 01/22/2025)***

1. 12/12/2024 – Listed medications were labeled in accordance with Regulation 184.b by RCC
2. 12/20/2024 – RWD re-educated on Regulation 184.b by Regional Director of Wellness Services (Exhibit 36)
3. By 2/8/2025 – Current Med Administration Staff re-educated on Regulation 184.b by Regional Director of Wellness Services (Exhibit 37)
4. Starting 1/20/2025 – RWD or designee will audit med carts weekly x 4 weeks to verify compliance with Regulation 184.b (Exhibit 38)
5. RWD or Designee will monitor for ongoing compliance

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

Implemented (- 02/27/2025)

185a - Implement Storage Procedures

15. 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 # 4 is prescribed Famotidine 20mg orally as needed for heartburn. This medication was not available in the home on 12/12/2024 at time of inspection.

Repeat Violation: 11/7/2023

Plan of Correction ***Accept (- 01/22/2025)***

1. 12/12/2025 – Medication listed was discontinued by physician
2. 12/20/2024 – RWD re-educated on Regulation 185.a by Regional Director of Wellness Services (Exhibit 39)
3. By 2/1/2025 – Current Med Administration Staff re-educated on Regulation 185.a by RWD
(Exhibit 40)
Starting 1/20/2025 - RWD or Designee will audit prescribed medications being available in compliance with Regulation 185.a weekly x 4 weeks (Exhibit 41)
4. RWD or Designee will monitor for ongoing compliance

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

Implemented (- 02/27/2025)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident # 5 has an order for Metoprolol 100 mg tab every 12 hours; hold for SBP less than 110 or HR less than 55. On 11/15/24 and 11/16/24 at 7am there was no documentation that the blood pressure or heart rate was taken prior to administering the medication.

Repeat Violation: 8/28/24

Plan of Correction ***Accept (█ - 01/22/2025)***

1. 12/20/2024 – RWD re-educated on Regulation 187.d by Regional Director of Wellness Services (Exhibit 42)
2. By 2/8/2025 – Current Med Administration Staff re-educated on Regulation 187.d by RWD (Exhibit 43)
3. Starting 1/20/2025 – RWD or Designee will audit 3 random Residents with medication orders containing parameters weekly x 4 weeks (Exhibit 44)
4. RWD or Designee will monitor for ongoing compliance

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

Implemented (█ - 02/27/2025)

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 Member A certification to administer medications expired 10/4/2024. Staff Member B's certification to administer medications expired 2/17/2024. The home has no documentation that Staff Member A or B were recertified but both staff members continue to administer medications.

Plan of Correction ***Accept (█ - 01/22/2025)***

1. 12/3/2024 – Staff Members A and B were removed from Med Administration assignment
2. 12/14/2024 – Staff Members A and B completed Med Administration Training (Exhibit 45)
3. 12/20/2024 – RWD and BOM re-educated on Regulation 190.a by Regional Operations Specialist/Certified Med Administration Trainer (Exhibit 46)
4. RWD and BOM developed Med Tech Compliance Tracking Tool (Exhibit 47)
5. BOM or Designee will monitor for ongoing compliance

Licensee's Proposed Overall Completion Date: *03/01/2025*

190a - Completion Medication Course *(continued)*

Implemented (- 03/31/2025)

224a - Preadmission Screen Form

18. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

During 12/3/2024 onsite inspection, it was determined that Resident # 6, admitted [redacted] and Resident # 7, admitted [redacted], did not have preadmission screening forms completed by the home.

Repeat Violation 11/7/2023

Plan of Correction ***Accept (- 01/22/2025)***

1. 12/12/2024 – ED completed Pre-screens on Residents 6 and 7 (Exhibit 48)

2. On 12/20/2024 – RWD, ED and CRD re-educated on Regulation 224.a by Regional Director of Wellness Services (Exhibit 49)

3. Starting 1/20/2025 – ED will audit charts of newly admitted residents for compliance of Regulation 224.a weekly x 4 weeks (Exhibit 50)

4. ED or Designee will monitor for ongoing compliance

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

Implemented (- 02/27/2025)

252 - Record Content

19. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
 2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident # 6 did not have their identifying marks, eye color, hair color, or religious affiliation documented in their chart.

Repeat Violation: 11/7/2023

Plan of Correction ***Accept (- 01/22/2025)***

1. 12/12/2024 – ED entered information into chart of Resident 6 within compliance of Regulation 252 (Exhibit 51)

2. 12/20/2024 – ED and RWD re-educated on Regulation 252 by Regional Director of Wellness Services (Exhibit 52)

3. Starting 1/20/2025 – ED or Designee will audit 3 random resident charts for compliance with Regulation 252

252 - Record Content (continued)

weekly x 4 weeks (Exhibit 53)
4. ED or Designee will monitor or ongoing compliance

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

Implemented ([redacted] - 02/27/2025)