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

February 13, 2025

[redacted], DIRECTOR OF HEALTH SERVICES
PENNSWOOD VILLAGE
1382 NEWTOWN-LANGHORNE ROAD
NEWTOWN, PA, 18940

RE: PENNSWOOD VILLAGE PERSONAL CARE HOME
1382 NEWTOWN-LANGHORNE ROAD
NEWTOWN, PA, 18940
LICENSE/COC#: 12675

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/09/2024 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: *PENNSWOOD VILLAGE PERSONAL CARE HOME* **License #**: *12675* **License Expiration**: *01/20/2025*

Address: *1382 NEWTOWN-LANGHORNE ROAD, NEWTOWN, PA 18940*

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

Administrator

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

Legal Entity

Name: *PENNSWOOD VILLAGE*

Address: *1382 NEWTOWN-LANGHORNE ROAD, NEWTOWN, PA, 18940*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *12/09/2024*

Inspection Dates and Department Representative

12/09/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *41* **Residents Served**: *35*

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**: *35*

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

Have Mobility Need: *13* **Have Physical Disability**: *0*

Inspections / Reviews

12/09/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/12/2025*

01/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/07/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/26/2025*

Inspections / Reviews *(continued)*

02/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/07/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/10/2025*

02/13/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/07/2025*

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

141a 1-10 Medical Evaluation Information

1. 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. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation, dated [redacted] indicates that the resident has a need by checking the "Listed below" box on (8) Body Positioning/Movement, but does not contain any information regarding this resident's specific need.

Plan of Correction ***Accept ([redacted] - 02/04/2025)***

Resident #1's DME was corrected on 12/10/24 by PCHA and approved by CRNP. The remainder of all PC residents DMEs were audited by PCHA on 12/10/24-12/11/24. An In-service was held by PCHA on 12/16/24-12/19/24 with all RN and LPN staff to review how to fill out a DME. A New process has been created to ensure all items are addressed and entered correctly. The new process will entail that the charge nurses from each shift will audit the DME upon its completion by the provider. Upon completion of the DME by the provider, the charge nurse from each shift will audit the DME confirming all information is entered correctly and will clarify any areas that may need correction. If any changes are made, the charge nurse is to document on the DME form, the provider who approved the change/correction and the date, if necessary. This audit will take place immediately after completion of a DME. This will be done for all DMEs – Initial, Annual, and Significant change. The DME will be reviewed by the charge nurses on all 3 shifts. The audit will then be reviewed by the Medical Records Coordinator with the final review by the Personal Care Home Administrator. This process began with the 1st DME of 2025, which was on 1/6/25. This process will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented ([redacted] - 02/13/2025)

141b1 - Annual Medical Evaluation

2. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation, dated [redacted], indicates that the resident has a need by checking the "Listed below" box on (8) Body Positioning/Movement, but does not contain any information regarding this resident's specific need.

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction ***Accept ([redacted] - 02/04/2025)***

Resident #2's DME was corrected on 12/10/24 by PCHA and approved by CRNP. The remainder of all PC residents DME's were audited for timeliness by PCHA on 12/10/24-12/11/24. An In-service was held by PCHA on 12/16/24-12/19/24 with all RN and LPN staff to review how to fill out a DME. A New process has been created to ensure all items are addressed and entered correctly. The new process will entail that the charge nurses from each shift will audit the DME upon its completion by the provider. Upon completion of the DME by the provider, the charge nurse from each shift will audit the DME confirming all information is entered correctly and will clarify any areas that may need correction. If any changes are made, the charge nurse is to document on the DME form, the provider who approved the change/correction and the date, if necessary. This audit will take place immediately after completion of a DME. This will be done for all DMEs – Initial, Annual, and Significant change. The DME will be reviewed by the charge nurses on all 3 shifts. The audit will then be reviewed by the Medical Records Coordinator with the final review by the Personal Care Home Administrator. This process began with the 1st DME of 2025, which was on 1/6/25. This process will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented ([redacted] - 02/13/2025)

183d - Prescription Current

3. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

The home keeps each resident's prescription medications in each resident's unit except for controlled medications and insulin supplies. On 12/09/2024, a bottle of Saline Nasal Spray was in resident #6's medication drawer; however, the medication was not listed on the resident's current order.

Plan of Correction ***Accept ([redacted] - 02/04/2025)***

The saline nasal spray found in resident #6's medication drawer was immediately removed by the Personal Care Home Administrator of the date of the inspection, 12/9/24. Monthly drawer checks were completed 12/9/24. An In-service was held by PCHA between the dates of 12/16-12/19/24 with all RN and LPN staff reviewing the new process for drawer checks to ensure that all prescription, OTC, sample and CAM medications are current. Drawer checks will occur bi-monthly by both the Med Techs and the charge nurse. The new drawer check process began on 1/1/25 and will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented ([redacted] - 02/13/2025)

184a - Resident's Meds Labeled

4. Requirements

2600.
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.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

Resident #7's order for Tramadol 50 mg reads '1 tab by mouth at bedtime until 12/02/2024' and every eight hours as needed. The resident has two separate blister cards and controlled medication logs for each order. The bedtime order and PRN order were merged into one but there is no direction change sticker on either blister card and nurses have been signing out bedtime dose from both cards.

Plan of Correction ***Accept ([redacted] - 02/04/2025)***

A direction change sticker was added to the blister cards and controlled medication logs for resident #7 on 12/9/24 as an immediate action step. PCHA conducted an audit of all narcotic record sheets against the eMAR to ensure all documentation is up-to-date, legible and correct on 12/10/24. An In-service was held by PCHA between the dates of 12/16-12/19/24 with all RN and LPN staff reviewing the 5 Rights of Medication administration. Reviewed with nursing that if an order has been updated, that there is a "Direction Change Refer to EMAR" sticker applied to all medication changes. The 24-hour chart check, which is completed each night by the 11p-7a nurse, has been updated to include checking that the order direction change has been applied to any applicable med changes. The 24-hour chart check is placed in the Personal Care Home Administrator's bin upon completion. The Personal Care Home Administrator will review the 24-hour narcotic sheet chart checks and conduct monthly narcotic sheet chart checks to ensure the process is being followed. This process began on 1/3/25 and will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented ([redacted] - 02/13/2025)

185a - Implement Storage Procedures

5. 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 #5 is prescribed Tramadol 50 mg three times a day and every eight hours as needed (PRN). The controlled medication log for PRN Tramadol 50 mg indicates that one pill was destroyed without necessity on 10/22/2024 due to a wrong documentation of the remaining balance (27) after 05:00 AM administration on 10/21/2024 when the actual balance was 28.

Plan of Correction ***Accept ([redacted] - 02/04/2025)***

PCHA conducted an audit of all narcotic record sheets against the eMAR to ensure all documentation is legible and correct on 12/10/24 as an immediate action step. Resident #5s orders were reviewed by the provider and an order to discontinue the PRN Tramadol was provided on 12/17/24. The Tramadol was destroyed by 2 nurses, per protocol. An In-service was held by PCHA between the dates of 12/16-12/19/24. PCHA reviewed with nursing that all documentation should be clear, correct and legible. The 24-hour chart check, which is completed each night by the 11p-7a nurse, has been updated to include checking that the counts are correct, dates are correct and documentation is legible. The Personal Care Home Administrator will review the 24-hour chart checks and conduct monthly narcotic sheet chart checks to ensure the process is being followed. This process began on 1/3/25 and will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

185a - Implement Storage Procedures *(continued)*

Implemented (- 02/13/2025)

186b - Medication Used by Resident

6. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 10/13/2024 at 09:00 PM, resident #4 was administered Oxycodone 5 mg prescribed for and belonging to resident #3.

Plan of Correction ***Accept (- 02/04/2025)***

The medication error occurred on 10/13/24 and was reported to DHS on 10/14/24. The resident's POA and provider were made aware of the above at the time of the error. The nurse reported that had pulled the Percocet for another resident, who lives in the same hall as resident #4. The nurse saw resident #4 when arrived in the hall on way to administer the medication and resident #4 began a conversation with the nurse. Resident #4 also has medication scheduled at the same time as hall neighbor, and the conversation between the nurse and resident #4 distracted the nurse, who then administered the Percocet in error to resident #4. The nurse immediately realized mistake and assessed the resident. The nurse making the error self-reported the error immediately. The physician and POA were made aware of the error. The resident was assessed by nursing and no ill effects were noted post administration. PCHA reviewed with the nurse on 10/14/25 the 5 Rights of Medication administration, including following the right medication for the right resident and a Med Error form was filled out and signed. The PCHA held an in-service between the dates of 12/16-12/19/24 with the nursing staff which included the 5 Rights of Medication administration. PCHA conducted an audit of all narcotic record sheets against the eMAR to ensure all documentation is legible and correct on 12/10/24. A root-cause analysis was completed 12/23/25. A med pass observation will be conducted quarterly to ensure all staff are following the Rights of Medication administration starting 1st quarter of 2025.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented (- 02/13/2025)

187b - Date/Time of Medication Admin.

7. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #8 is prescribed Morphine 0.25 ml every one hour as needed. Resident #8's December medication administration record does not include the initials of the staff person who administered it on 12/08/2024 at 09:45 AM.

Plan of Correction ***Accept (- 02/04/2025)***

PCHA conducted an audit of all narcotic record sheets against the eMAR to ensure all documentation is legible, correct and properly signed out on the narcotic records sheets and eMAR on 12/10/24 as an immediate action step. No other missing initials on eMAR noted. An In-service was held by PCHA between the dates of 12/16-12/19/24. PCHA reviewed with nursing that all medications administered on the narcotic sign out sheet must also be signed

187b - Date/Time of Medication Admin. (continued)

out on the eMAR. The 24-hour chart check, which is completed each night by the 11p-7a nurse, has been updated to include checking that any PRN medication signed out matches on both the narcotic sign out sheet and the eMAR. The Personal Care Home Administrator will review the 24-hour chart checks and conduct monthly narcotic count sheet chart checks to ensure the process is being followed. This process began on 1/3/25 and will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented ([redacted] - 02/13/2025)

227d - Support Plan Medical/Dental

8. 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

Resident #6's most recent assessment and support plan (RASP) dated [redacted] indicates that the resident has no problem with irritability, judgement, agitation, or aggression; however, the resident slapped resident #5 on the face on [redacted] when told to move on the way to the dining room. The home failed to update resident #6's RASP with this incident.

Plan of Correction ***Accept ([redacted] - 02/04/2025)***

The RASP addendum for resident #6 was updated on 12/10/24 by PCHA. An audit of the remaining RASPS was conducted between the dates of 12/10-12/11/24 to ensure all RASPs are up-to-date. During the in-service held by PCHA on the dates of 12/16-12/19/24, PCHA reviewed with nursing that a RASP must be updated as needed for minor changes in resident's care and that if a resident has a change in condition or significant change then a new DM and RASP will be needed within 5 days of the change. RASPs are reviewed by the PCHA upon completion. A quarterly audit of the RASPs will be conducted by the PCHA. The quarterly audit will be based on the date of the resident's most current finalized RASP. This will begin in January 2025 and will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented ([redacted] - 02/13/2025)

251b - Record Entries Legible

9. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The controlled medication log for resident #5's PRN Tramadol 50 mg (1/2 tab every eight hours as needed) was written over on the date and remaining balance on the 3rd entry.

Plan of Correction ***Accept ([redacted] - 02/04/2025)***

PCHA conducted an audit of all narcotic record sheets against the eMAR to ensure all documentation is legible and correct on 12/10/24 as an immediate action step. An in-service was held by the PCHA on the dates of 12/16-12/19/24. PCHA reviewed with nurses the importance of having clear and legible documentation. The 24-hour

251b - Record Entries Legible (continued)

chart check, which is completed by the 11p-7a charge nurse, has been updated to include checking that the counts are correct, the dates are correct and that the documentation is legible. The Personal Care Home Administrator will review the 24-hour chart checks after nurse's completion and conduct monthly narcotic count sheet/ chart audits to ensure the process is being followed. This process began on 1/3/25 and will be ongoing.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Implemented ([redacted] - 02/13/2025)