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

February 18, 2025

[redacted]
HSL DOUGLASSVILLE SUBTENANT LLC
[redacted]
C/O HERITAGE SENIOR LIVING
[redacted]

RE: KEYSTONE VILLA AT
DOUGLASSVILLE PERSONAL CARE
1152 BEN FRANKLIN HIGHWAY
EAST
DOUGLASSVILLE, PA, 19518
LICENSE/COC#: 22768

[redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/17/2024 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *KEYSTONE VILLA AT DOUGLASSVILLE PERSONAL CARE* **License #**: *22768* **License Expiration**: *06/13/2025*

Address: *1152 BEN FRANKLIN HIGHWAY EAST, DOUGLASSVILLE, PA 19518*

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

Administrator

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

Legal Entity

Name: *HSL DOUGLASSVILLE SUBTENANT LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/12/1989* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *184* **Waking Staff**: *138*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *12/17/2024*

Inspection Dates and Department Representative

12/17/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *168* **Residents Served**: *130*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *secured* **Capacity**: *68* **Residents Served**: *51*

Hospice

Current Residents: *22*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *130*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *54*

Have Physical Disability: *0*

Inspections / Reviews

12/17/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/17/2025*

01/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/17/2025*

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

Inspections / Reviews *(continued)*

01/29/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/17/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/17/2025*

02/18/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/17/2025*

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [redacted] resides in the secure [redacted] and has a diagnosis of [redacted] The Residents Assessment and Support plan indicate the resident needs total physical assistance with toileting. Resident was on a toileting schedule. However, the home was not adhering to the schedule. Between [redacted] and [redacted], the resident was not toileted every 2 hours on 27 different occasions.

Plan of Correction ***Directed [redacted] 01/29/2025)***

Immediate Corrective Action:
The toilet tracker worksheet used by staff is a community tool to track when a resident was last assisted with continence care. The tracker is not meant to show residents need a specific schedule nor that they are toileted every two hours, and its purpose was misunderstood when reviewed. The community, under the leadership of the Executive Director and Resident Care Director, will discontinue use of the worksheet and will have continence care assigned and verified electronically in each resident's task list in TabulaPro. This will reflect the toileting needs of each resident as identified in their RASP. This individualized task list will be in place by 2/13/25. The task list will show all needed continence care based on the RASP, and staff will document completion of it. The Executive Director and Resident Care Director will ensure the task lists are set up according to the RASP and will provide oversight for completion and compliance. The set up of the task lists will be completed by 2/13/25, and staff will begin using them immediately on 2/13/25.

Additional Corrective Action: The Executive Director will educate direct care staff at the next scheduled staff meeting on 2/13/25 to understand that any toileting schedule for a resident is based on the needs identified in each resident's RASP and will be assigned and documented in the task list. They will be instructed on how to use the task list to document the completion of continence care, and will begin using the task list as of 2/13/25.

Ongoing Quality Assurance: The Resident Care Director will audit the task list report weekly for compliance, beginning February 20, 2025. The task list report will show the completion of documentation that verifies continence care is provided as assigned, based on the needs identified in the RASP. Concerns will be addressed when/if identified with staff, individually or in staff meetings. Overall findings and compliance will be reviewed at the next quarterly quality assurance meeting being held in April 2025 to review the first quarter of 2025. QA Meetings are conducted by the Executive Director, in meeting with all Department Managers, which includes the Managers overseeing resident care.

Proposed Overall Completion Date: 02/13/2025

Directed: In addition to the above plan of correction, the administrator or designee will complete random interviews with at least 4 residents weekly regarding staff providing timely assistance with their ADL's. The home will keep at a minimum a list of residents interviewed, the date of the interview, the person completing the interview, concerns identified in the interview, and actions taken if any concerns were identified. These interviews will be completed for 1 month beginning 2/2/2025.

Directed Completion Date: *03/02/2025*

23a - Activities of Daily Living Assistance *(continued)*

Implemented [redacted] - 02/18/2025)

42b - Abuse

2. 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

Resident [redacted] resides in the home's secure dementia unit and has a diagnosis of dementia. On [redacted] at approximately 3am, resident [redacted] reported to staff that [redacted] had been punched in the head two times and pushed by staff person A. Staff who responded to the resident's room after hearing the resident yelling for help indicated that upon arrival, resident [redacted] appeared disheveled and had a skin tear on their elbow. Staff also stated that upon arrival to the resident's room, staff person A stated, "this [redacted] is crazy" and stated that resident [redacted] had pulled their name tag off.

Resident [redacted] resides in the secure [redacted] and has a diagnosis of [redacted]. On [redacted], after numerous falls the home and the residents Power of Attorney signed a Confounding Factors Discussion and Agreement for Alternative Records. It was agreed that the home would continue with the toilet and safety tracker. The resident was to be toileted every 2-hours and a staff person was to check on the resident every hour. The toilet tracking documentation shows that on 27 occasions between [redacted] and [redacted] Resident [redacted] was not toileted every 2 hours. Also, through staff interviews it was determined that staff were not checking on the resident every hour as agreed upon, to prevent falls. On [redacted], and [redacted] Resident [redacted] had additional unwitnessed falls. On [redacted], the fall resulted in the resident getting a head laceration that required staples.

Repeat Violation: [redacted]

Plan of Correction ***Directed ([redacted] - 01/29/2025)***

Resident [redacted]
Immediate Corrective Action: Resident [redacted] was assessed immediately on [redacted] and [redacted] skin tear was cleaned and covered. Staff Member A was suspended pending the community's investigation.

Additional Corrective Action: The community, led by the Executive Director, completed a thorough investigation. The incident occurred on the resident's first night at the community. [redacted] was anxious and overwhelmed in [redacted] new environment. Resident [redacted] was not able to sleep, was restless, and repeatedly tried to wake [redacted] roommate and remove [redacted] blanket. Staff Member A stayed in the apartment to redirect Resident [redacted] away from [redacted] roommate. Staff member A reports that Resident [redacted] became aggressive, began yelling, and pulled off [redacted] name tag and lanyard around 3:20am [redacted]. When staff responded to the apartment, Resident [redacted] stated Staff member A punched [redacted] on the head twice and pushed [redacted] onto the bed. A staff member who responded to the apartment began yelling at Staff Member A and the two engaged in a verbal altercation outside of the resident's apartment.

The next morning both the Executive Director and Resident Care Director met with Resident [redacted]. [redacted] was unable to clearly and accurately confirm what happened, was confused about what transpired, and showed no signs of distress nor further injury. There was no indication [redacted] had been struck in the head. Berks County Area Agency on Aging responded to the Act 13 reported by Keystone Villa. Resident [redacted] was interviewed and had no recollection of stating [redacted] was punched in the head and pushed on the bed.

42b - Abuse (continued)

As the staff continued to learn more about Resident [redacted] since [redacted] admission, it was discovered [redacted] has increased paranoia and anxiety at night which led [redacted] to strike out at staff and experience difficulty sleeping. Resident [redacted] was seen by a Geriatric Psychiatrist on [redacted] with orders to continue current medications, prescribed medication to aid with sleeping, and prescribed PRN medications for anxiety. On [redacted], [redacted] PCP ordered assessment by behavioral health for agitation and anxiety. On [redacted], Resident A's PCP prescribed medication for depression on the recommendation from behavioral health. The medications have helped Resident A's agitation and anxiety.

The abuse investigation completed by Keystone Villa is unfounded. Staff member A was terminated based on [redacted] reaction and insubordination to the Resident Care Director when told that [redacted] was suspended pending the investigation.

Ongoing Quality Assurance: The community takes allegations of abuse very seriously and will continue to self-report incidents that occur to the Department of Human Services. The Executive Director will provide training to the staff on the next scheduled staff meeting, 2/13/25, on how handle challenging situations with residents and staff.

Resident 1:
Immediate Corrective Action: The Memory Care Director reviewed the resident's fall risk level form on 12/17/24 and updated the fall risk to high also updating the RASP. The Memory Care Director completed a falls risk interventions form on 12/17/24, identifying the interventions to be implemented for each risk factor, and updated the RASP. The confounding factors form reviewed with the family states that staff will continue with the toileting tracker and safety checks. The toilet tracker worksheet used by staff is a community tool to track when a resident was last assisted with continence care. The tracker is not meant to show residents need a specific schedule nor that they are toileted every two hours, and its purpose was misunderstood when reviewed. The community, under the leadership of the Executive Director and Resident Care Director, will discontinue use of the worksheet and will have continence care and safety checks assigned and verified electronically in each resident's task list in TabulaPro. This will reflect the toileting and safety check needs of each resident as identified in their RASP. This individualized task list will be in place by 2/13/25. The task list will show all needed continence care and safety checks based on the RASP, and staff will document completion of it. The Executive Director and Resident Care Director will ensure the task lists are set up according to the RASP and will provide oversight for completion and compliance. The set up of the task lists will be completed by 2/13/25, and staff will begin using them immediately on 2/13/25.

Additional Corrective Action: The Executive Director will educate direct care staff at the next scheduled staff meeting on 2/13/25 to understand that any toileting and/or safety check schedule for a resident is based on the needs identified in each resident's RASP and will be assigned and documented in the task list. They will be instructed on how to use the task list to document the completion of continence care and safety checks, and will begin using the task list as of 2/13/25.
Ongoing Quality Assurance: The Resident Care Director will audit the task list report weekly for compliance, beginning February 20, 2025. The task list report will show the completion of documentation that verifies continence care and safety checks is provided as assigned, based on the needs identified in the RASP. Concerns will be addressed when/if identified with staff, individually or in staff meetings. Overall findings and compliance will be reviewed at the next quarterly quality assurance meeting being held in April 2025 to review the first quarter of 2025. QA Meetings are conducted by the Executive Director, in meeting with all Department Managers, which includes the Managers overseeing resident care.

42b - Abuse (continued)

Proposed Overall Completion Date: 02/13/2025

Directed: In addition to the above plan of correction, all staff will be trained in resident rights by 2/13/2025. The administrator or designee will complete random interviews with at least 4 residents weekly regarding their treatment in the home by staff. The home will keep at a minimum a list of residents interviewed, the date of the interview, the person completing the interview, concerns identified in the interview, and actions taken if any concerns were identified. These interviews will be completed for 1 month beginning 2/2/2025.
Resident [redacted] will be checked at a minimum of every hour for the next 2 weeks. This will be documented by staff initialing paperwork indicating the date and time that the resident was seen. The administrator or designee will review Resident 1's status weekly and increase checks if needed. After 2 weeks the resident can be reassessed and time between checks can be reevaluated but must continue at a minimum of every 2 hours. Any change to the interval of checks completed by the home will be done only if the administrator or designee competes an assessment that is documented in the resident record indicating the new intervals are appropriate in maintaining the safety of Resident [redacted].

Directed Completion Date: *03/02/2025*

Implemented [redacted] - 02/18/2025)

234d - Support Plan Revision

3. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident [redacted] is on a toileting and safety checks schedule. This information was not documented in the resident assessment and support plan.

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

Immediate Corrective Action: The RASP was updated by the Executive Director on 12/17/25 to include their toileting and safety check schedule.

Additional Corrective Action: Care Management staff were retrained by the Executive Director on 1/14/25 to include a toileting and safety check schedule, if needed, on the resident's RASP.

Ongoing Quality Assurance: The Executive Director will audit 5% resident's RASP's monthly, beginning in January 2025, for compliance and will report the findings at the next quarterly quality assurance meeting being held in April 2025, in review of the first quarter 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/18/2025)