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

April 16, 2025

[redacted]
DISCOVERY READING LEASING LLC
[redacted]
SUITE 201
[redacted]

RE: RITTENHOUSE VILLAGE AT MUHLENBERG
2900 LAWN TERRACE
READING, PA, 19605
LICENSE/COC#: 22802

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/09/2025, 01/21/2025 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]y
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *RITTENHOUSE VILLAGE AT MUHLENBERG* **License #**: *22802* **License Expiration**: *05/01/2025*

Address: *2900 LAWN TERRACE, READING, PA 19605*

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

Administrator

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

Legal Entity

Name: *DISCOVERY READING LEASING LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *11/17/2009* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *101* **Waking Staff**: *76*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *01/21/2025*

Inspection Dates and Department Representative

01/09/2025 - On-Site: [redacted]

01/21/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served**: *87*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *87*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *14* **Have Physical Disability**: *3*

Inspections / Reviews

01/09/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/21/2025*

03/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/09/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/07/2025*

Inspections / Reviews *(continued)*

03/14/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/09/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/04/2025*

04/16/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/09/2025*

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

15c - Supervision

1. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted] an allegation of suspected abuse was made against Staff Member D. After the home conducted an internal investigation the staff member returned to work on [redacted] however a plan of supervision was not approved by the Department.

Plan of Correction ***Accept [redacted] 03/05/2025)***

The Executive Director conducted training for the Director of Health and Wellness on this regulation on January 10th, 2025. Effective January 10, 2025, the Executive Director is responsible for completing and submitting the plan to the DHS regional office for approval before having a staff member return from suspension. If the Executive Director is absent, the Director of Health and Wellness will assume responsibility for ensuring that this plan is completed and submitted in a timely manner. (see the attached training sheet)

Licensee's Proposed Overall Completion Date: *02/21/2025*

Implemented [redacted] 04/16/2025)

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

On [redacted] at approximately 5pm, Resident [redacted] was discovered in bed covered in dried urine and feces by Staff Member B and Staff Member C. Through interviews with staff of the home, it was confirmed that staff member A last completed an incontinence check on Resident [redacted] after breakfast that day and failed to provide the assigned care which was to be provided to the resident every 2 hours through the remainder of the staff member's shift. Resident [redacted] is incontinent of bowel and bladder, requires 2 hour incontinence checks and full physical assistance by staff to meet these needs of the resident.

Plan of Correction ***Directed ([redacted] - 03/14/2025)***

On January 10, 2025, the Executive Director retrained the nursing team on the relevant regulation concerning resident care, specifically emphasizing the importance of ensuring that residents are clean and well taken care of before leaving their shifts. Additionally, we have scheduled a mandatory training session on empathy, dignity, and respect, which will be conducted by an external resource (Carin Hospice) on January 29, 2025. We will be reviewing residents' rights training quarterly during our all-staff meetings. (see the attached training sheet)

See document #2 - Task sheets reflecting the two-hour checks.

I have also included document #1 - requested training sheet for violation 15,c and document #3 - termination form, document #4 training sheet, #5 audits for violation 54.a

42b Abuse (continued)

Proposed Overall Completion Date: 03/07/2025

(Directed)
Effective immediately the Administrator will audit completion of two hour check sheets daily for 4 weeks and then weekly thereafter. Documentation of audits shall be kept.

Directed Completion Date: *04/04/2025*

Implemented [redacted] - 04/16/2025)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

Description of Violation

Staff Member A has a college diploma from [redacted]. The home did not apply for a waiver from the Department regarding the non US diploma.

Plan of Correction ***Accept [redacted] - 03/05/2025)***

The staff member with the high school diploma from out of state was terminated on [redacted], due to an investigation. On January 10, 2025, the Executive Director trained our Business Office Manager, who oversees the onboarding process. This training focused on the relevant regulations and procedures to ensure compliance and enhanced the effectiveness of our onboarding practices to ensure compliance. The Business Office Manager will conduct a comprehensive audit of all employee files and develop a tracking system by 2/28/25 to ensure compliance. Effective February 18, 2025, the Business Office Manager will perform audits of the employee files quarterly to maintain compliance. (see the attached training sheet)

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

Implemented [redacted] - 04/16/2025)

141b1 - Annual Medical Evaluation

4. Requirements

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

Description of Violation

Resident [redacted] most recent Documentation of Medical Evaluation was completed on [redacted]

Plan of Correction ***Accept [redacted]/05/2025)***

The root caused analysis determined that the resident did not have a DME completed in 2024. A new DME was completed on January 10, 2025. The Director of Health and Wellness was trained on this regulation and POC on January 10, 2025. The Director of Health and Wellness has completed a thorough audit of all charts and ensured that all DMEs were finalized by February 1st, 2025. Effective January 15, 2025, the Director of Health and Wellness follows a tracking system designed to keep all DMEs up to date. This system will be reviewed monthly to ensure that all DMEs remain current and compliant. (see the attached supporting documentation)

Licensee's Proposed Overall Completion Date: *02/21/2025*

141b1 - Annual Medical Evaluation *(continued)*

Implemented [redacted] - 04/16/2025)

183b - Meds and Syringes Locked

5. 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 [redacted] at approximately 1:02pm, an unlocked and unattended medication cart was observed in hallway of the home near resident room [redacted]

Plan of Correction ***Directed [redacted] - 03/14/2025)***

The Executive Director conducted a comprehensive training session on January 10, 2025, for the nursing team, emphasizing the critical importance of ensuring that all medication carts are securely locked whenever they are out of sight. To reinforce these practices, the medication technicians are now responsible for verifying that the medication carts are locked immediately after each medication passes. Ongoing supervision and periodic refresher training will be implemented to support adherence to these practices. (see the attached training sheet)

An additional training was provided by the Executive Director to the Director of Health and Wellness and the Health Care Coordinator on med cart audits. I have included document #8 - training sheet and document #9 - med cart audit spreadsheet.

I have included document #6 - resident DME, document #7 - DME audit, document #1 - DHW training for violation 141.b1

I have included document #10 - RASP, document #11 - RASP audit, document #1 - DHW training

Proposed Overall Completion Date: 03/07/2025

(Directed)
Effective immediately the Administrator will complete weekly walk throughs of the building on different days and shifts to ensure prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked. Documentation of audits will be kept.

Directed Completion Date: *04/04/2025*

Implemented [redacted] - 04/16/2025)

225c - Additional Assessment

6. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident [redacted]s most recent Resident Assessment Support Plan was completed on [redacted]

225c - Additional Assessment *(continued)*

Plan of Correction ***Accept [redacted] - 03/05/2025)***

The root caused analysis determined that the annual RASP needed to be completed by December 8, 2024. The annual RASP was completed on January 9, 2025. The Director of Health and Wellness was trained on this regulation and POC on January 10, 2025. The Director of Health and Wellness has completed a thorough audit of all charts and ensured that all RASPs were finalized by February 1st, 2025. Effective January 15, 2025, the Director of Health and Wellness follows a tracking system designed to keep all RASPs up to date. This system will be reviewed monthly to ensure that all RASPs remain current and compliant. (see the attached supporting documentation)

Licensee's Proposed Overall Completion Date: *02/21/2025*

Implemented [redacted] - 04/16/2025)