

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

March 11, 2025

[REDACTED], EXECUTIVE DIRECTOR
LEBANON VALLEY BRETHREN HOME
1200 GRUBB STREET
PALMYRA, PA, 17078

RE: LEBANON VALLEY BRETHREN
HOME
1200 GRUBB STREET
PALMYRA, PA, 17078
LICENSE/COC#: 34296

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/07/2025 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEBANON VALLEY BRETHERN HOME* License #: 34296 License Expiration: 06/14/2025
 Address: 1200 GRUBB STREET, PALMYRA, PA 17078
 County: *LEBANON* Region: *CENTRAL*

Administrator

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

Legal Entity

Name: *LEBANON VALLEY BRETHERN HOME*
 Address: 1200 GRUBB STREET, PALMYRA, PA, 17078
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *05/08/1990* Issued By: *Dept. of Labor and Industry*

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 36 Waking Staff: 27

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *02/07/2025*

Inspection Dates and Department Representative

02/07/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 58 Residents Served: 36

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

Hospice
 Current Residents: 0

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 36
 Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

02/07/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/01/2025*

03/03/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *03/06/2025*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/10/2025*

Inspections / Reviews *(continued)*

03/06/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/06/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 03/16/2025

03/11/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/06/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

51 - Criminal Background Check

1. Requirements

2600.

- 51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Person A has been volunteering at the home since [REDACTED]. However, Staff Person A does not have a Pennsylvania State Police criminal background check.

Plan of Correction

Accept ([REDACTED] - 03/06/2025)

- 1. Resident Services Assistant performed an audit 2/21/2025 of all personal care volunteer files to ensure background checks were available.
- 2. Background checks being completed by human resources or designee on all current volunteers found to not have a background check for Personal Care including Staff Person A to be completed by 3/4/25.
- 3. Volunteers will not be allowed to volunteer in Personal Care until background check is completed.
- 4. Resident Services Assistant and Human Resources were educated about regulation 2600.51 and their role in ensuring compliance on 3/3/2025.
- 5. Checklist created and implemented on 2/26/2025 for all future new volunteer applicants to ensure requirements are met prior to starting their duties.
- 5. PC administrator or designee will verify that background check is on file for next 3 new volunteers beginning 3/3/2025, if any further issues will continue monitoring until 3 successful verifications.

Proposed Overall Completion Date: 02/26/2025

Proposed Overall Completion Date: 03/03/2025

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

Implemented ([REDACTED] - 03/11/2025)

65a - FS Orientation 1st Day

2. Requirements

2600.

- 65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff Person A has been volunteering at the home since [REDACTED], and Staff Person B has been volunteering at the home since [REDACTED]. However, Staff Person A and Staff Person B did not receive orientation on the following topics:

- (1) Evacuation procedures.
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

65a - FS Orientation 1st Day (continued)

Plan of Correction

Accept ([redacted] - 03/06/2025)

1. Resident Services Assistant performed an audit 2/26/25 of all personal care volunteer files to ensure fire safety and emergency preparedness training records were on file for all volunteers.
2. All volunteers who have not completed the required training will be scheduled to complete training on fire safety and emergency preparedness with Security Supervisor or designee to be completed by 3/21/25.
3. Checklist created for all future volunteer applicants to ensure requirements are met prior to starting their duties. Checklist implemented on 2/26/25.
4. Resident Services Assistant and human resources were educated on regulation 2600.65a on 3/3/2025 by PC administrator
5. PC administrator or designee will verify that fire safety and emergency preparedness training is on file for next 3 new volunteers beginning 3/3/25, if any further issues will continue monitoring until 3 successful verifications.

Proposed Overall Completion Date: 02/26/2025

Licensee's Proposed Overall Completion Date: 03/04/2025

Implemented ([redacted] - 03/11/2025)

65g - Annual Training Content

3. 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:

Description of Violation

Staff Person A has been volunteering at the home since [redacted], and Staff Person B has been volunteering at the home since [redacted]. However, Staff Person A and Staff Person B have not received the following annual training during the 2022, 2023 and 2024 training year:

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
- (3) Resident rights.
- (4) The Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102).
- (5) Falls and accident prevention.
- (6) New population groups that are being served at the home that were not previously served, if applicable.

Plan of Correction

Accept ([redacted] - 03/06/2025)

1. PC administrator and Residential Services Assistant met on 2/21/25 to discuss current education practices for PC volunteers.
2. Education on 2600.65g and their role to ensure compliance provided to Human resources and resident services assistant on 3/3/25 by PC administrator.
3. Education plan created to catch up current volunteers on annual education requirements and implement with all new volunteers. Plan includes Fire Safety, Emergency Preparedness, Resident Rights, Older Adult Protective Services Act, Falls and Accident Prevention, and new population groups (if applicable).
4. Training materials placed in a binder for easy review by volunteers. Volunteers will review and sign off on completion of education.
5. Annual training to be offered annually on month of starting volunteer duties.

65g - Annual Training Content (continued)

- 6. Any volunteers unable or unwilling to complete requirements will not be allowed to volunteer in personal care.
- 7. PC administrator or designee will audit volunteer files quarterly beginning 3/10/2025 to ensure compliance.

Proposed Overall Completion Date: 03/10/2025

Licensee's Proposed Overall Completion Date: 03/10/2025

Implemented () - 03/11/2025

121a - Unobstructed Egress

4. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 02/07/2024, at 10:13AM, the exit door labeled #35 by the dining room had two cardboard boxes and a rollator walker blocking the exit.

Plan of Correction

Accept () - 03/03/2025

- 1. 2 cardboard boxes and rollator walker immediately removed from area.
- 2. Bookshelf by exit door moved to allow resident to continue to place their walker by exit door without blocking egress on 2/10/25.
- 2. All staff educated on regulation 2600.121a on 2/20/25.
- 3. PC Administrator or designee on 2/10/25 began walking rounds at random times throughout PC to check exits and egresses to ensure clear routes for 3 weeks. If no further concerns identified will stop rounds. If issue continues will continue until 3 audits without any blocked egresses are completed.

Licensee's Proposed Overall Completion Date: 02/20/2025

Implemented () - 03/11/2025

123b - Emergency Procedures Posted

5. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction

Accept () - 03/06/2025

- 1. Emergency procedures binder immediately placed in public place outside nursing office.
- 2. On 2/8/25 Security supervisor began reviewing and updating emergency procedures binder. Placed in binder outside nursing office in a conspicuous and public place on 2/21/25.
- 3. Education provided to security staff members on 2/19/25 on Regulation 2600.123b.
- 3. Quarterly audits beginning 3/3/2025 will be completed by PC Administrator or designee to ensure emergency binder remains in a conspicuous and public place.

Proposed Overall Completion Date: 03/04/2025

123b - Emergency Procedures Posted (*continued*)

Licensee's Proposed Overall Completion Date: 03/04/2025

Implemented (█) - 03/07/2025

132d - Evacuation

6. 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

During two staff interviews, it was reported the home will "redo" fire drills if the fire drill is over the maximum safe evacuation time specified by a fire safety expert. Staff reported that there are times in which residents do not evacuate in time and/or residents refuse to evacuate. Staff stated if this occurs, the drill is not documented, and the home will continue to perform a fire drill until everyone in the home is evacuated under the maximum safe evacuation time. The last failed fire drill was reported by staff to have occurred in December of 2024. Staff reported this drill was re-done.

Furthermore, documentation for the 09/24/2024 fire drill contained correction tape on the following areas:

- *Exit route(s) used.*
- *Number of residents in the home at time alarm sounds.*
- *Number of staff participating.*
- *Was alarm activated.*
- *Was alarm operative.*

Also, documentation for the 04/26/2024 fire drill contained correction tape on the following areas:

- *Number of residents in the home at time alarm sounds.*
- *Planned corrective action.*

Plan of Correction

Accept (█) - 03/06/2025

1. *2/19/25 All staff responsible for fire drills educated on regulation 2600.132d and their responsibilities regarding documentation of fire drills.*
2. *2/19/25 All staff responsible for fire drills educated on not using correction tape on any documentation for fire drills.*
3. *Quarterly audits beginning 3/3/2025 will be completed by PC administrator or designee to ensure meeting all regulatory requirements for fire drills including completing in safe evacuation time, repeating if necessary and recording all fire drills, ensuring correction tape is not being used on monthly fire drill logs.*

Proposed Overall Completion Date: 03/04/2025

Licensee's Proposed Overall Completion Date: 03/04/2025

Implemented (█) - 03/07/2025

183d - Prescription Current

7. 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

On 02/07/2024, at 3:13PM, Mometasone Furoate nasal spray prescribed for Resident 1 was observed in the home's medication cart. However, there is not a current order for this medication.

Plan of Correction

Accept (█ - 03/03/2025)

1. Medication was immediately removed from medication cart and disposed of using facility protocols by LPN.
2. PC Administrator or designee will complete weekly audit starting 2/17/2025 of med cart to ensure only medications with current order are located in cart for 4 weeks. If concerns are found during 4 weeks, will continue until 4 weeks of audits completed with no errors. If no concerns found in 4 weeks of audits, will begin monthly audits.
4. Med Techs and LPNs educated on 2/20/25 regarding regulation and need to ensure only medications with orders be kept on hand.

Licensee's Proposed Overall Completion Date: 02/20/2025

Implemented (█ - 03/07/2025)

187d - Follow Prescriber's Orders

8. Requirements

2600.

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

Description of Violation

Resident 2 is prescribed HumaLOG KwikPen Subcutaneous Solution Pen-Injector 100UNIT/ML with orders to Inject as per the following sliding scale:

141-180= 2 units

181-220= 4 units

221-260= 6 units

261-300= 8 units

301-350= 10 units

351-400= 12 units

401+= 14 units

On 02/02/2025, at 4:30PM, Resident 2 had a blood sugar reading of 192 which would require 4 units of insulin to be injected. However, no insulin was administered to the resident.

Resident 2 is prescribed Lantus subcutaneous solution 100UNIT/ML with orders to inject 50 unit subcutaneously at bedtime. However, on 01/29/2025, this medication was not administered.

Resident 3 was prescribed Sudafed PE sinus congestion oral tablet with orders to give 1 tablet by mouth 2 times a day for sinus congestion and to monitor the resident's blood pressure due the medication may increase the resident's blood pressure. On 1/10/2025 and 01/11/2025, at breakfast, the medication was administered. However, the blood pressure was not measured.

187d - Follow Prescriber's Orders (continued)

Plan of Correction

Accept (█ - 03/03/2025)

1. All staff that administer medications were re-educated on the importance of following all directions provided by the prescriber on 2/26/25.
2. PC administrator or designee will complete daily audits starting 2/24/2025 of administration documentation x2 weeks. If no errors found, will begin weekly audits x4. If no issues found, will begin quarterly audits as part of the quality management plan.
3. If errors are found during the above audits, individual staff education will occur.

Licensee's Proposed Overall Completion Date: 02/26/2025

Implemented (█ - 03/07/2025)

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

Documentation for the 09/24/2024 fire drill contained correction tape on the following areas:

- Exit route(s) used.
- Number of residents in the home at time alarm sounds.
- Number of staff participating.
- Was alarm activated.
- Was alarm operative.

Documentation for the 04/26/2024 fire drill contained correction tape on the following areas:

- Number of residents in the home at time alarm sounds.
- Planned corrective action

Plan of Correction

Accept (█ - 03/06/2025)

1. All staff educated on regulation 2600.251b on 2/20/25.
2. Correction tape removed from nursing office on 2/7/25.
3. Quarterly audits beginning 3/3/2025 will be completed by PC administrator or designee to ensure correction tape is not being used on monthly fire drill logs.

Proposed Overall Completion Date: 03/04/2025

Licensee's Proposed Overall Completion Date: 03/04/2025

Implemented (█ - 03/11/2025)