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

May 14, 2025

PHOEBE BERKS HEALTH CARE CENTER, INC.

RE: PHOEBE BERKS VILLAGE
1 READING DRIVE
WERNERSVILLE, PA, 19565
LICENSE/COC#: 20536

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/26/2025, 04/01/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PHOEBE BERKS VILLAGE* **License #**: *20536* **License Expiration**: *07/30/2025*

Address: *1 READING DRIVE, WERNERSVILLE, PA 19565*

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

Administrator

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

Legal Entity

Name: *PHOEBE BERKS HEALTH CARE CENTER, INC.*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/04/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/26/2025*

Inspection Dates and Department Representative

03/26/2025 - On-Site:

04/01/2025 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *81*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Gardens* **Capacity**: *37* **Residents Served**: *29*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *81*

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

Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

03/26/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/01/2025*

05/02/2025 - POC Submission

Submitted By: **Date Submitted**: *05/02/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/09/2025*

Inspections / Reviews *(continued)*

05/14/2025 Document Submission

Submitted By: [redacted]

Date Submitted: *05/02/2025*

Reviewer: [redacted]

Follow Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On a police officer came to the home to report that resident had made several calls to a wrong number and left messages that they were imprisoned in the home. Out of concern, the person receiving the calls notified police and a police officer was sent to the home to make them aware of the calls. A review of resident nursing notes indicated that on several dates resident made verbal accusations of abuse against staff:
—resident told another resident that they were tied up and whipped.
—resident claimed mistreatment by nurses, being tied up, and being unable to leave their room.
—resident claimed that staff hits them, steals their phone, and the remote.
—when speaking to a nurse resident stated "when you are not here they lock me in my room".

The home did not report the resident's claims of abuse from staff to the Area agency on Aging as required.

Plan of Correction ***Accept - 05/01/2025)***

On 4/1/2025 all staff was reducated on the importance of completing a timely report of any allegations and presented with a "Med Tech Survival Guide", a page is the guide is: "ALLEGATIONS: Any allegations by a Resident must be reported to the administrator immediately. Whether believable or not, so that the state can be notified. Please do make sure you document them in PCC and notify the Administor or Designee immediately (i.e. someone stole my cell phone, but it was found in their nightstand), it still has to be reported."
Police were dispatched the community and found no incidents of concern (see attached police report)
Administrator contact Protective Services Supervisor on 4/28/25 and made the report and sent attached Act 13 and police report to AAA.
Audits of allegations will be completed by PCHA / Designee monthly x 3 months to ensure they have been appropriately reporting any allegation. Results of audits will be reported to QAA Committee.

Licensee's Proposed Overall Completion Date: *04/28/2025*

Implemented - 05/12/2025)

16c - Written Incident Report

2. 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

On a police officer came to the home to report that resident had made several calls to a wrong number and left messages that they were imprisoned in the home. Out of concern, the person receiving the calls notified police and a police officer was sent to the home to make them aware of the calls. A review of resident s nursing notes indicated that on several dates resident made verbal accusations of abuse against staff:

16c Written Incident Report (continued)

[redacted] resident [redacted] told another resident that they were tied up and whipped.
[redacted] resident [redacted] claimed mistreatment by nurses, being tied up, and being unable to leave their room.
[redacted] resident [redacted] claimed that staff hits them, steals their phone, and the remote.
[redacted] when speaking to a nurse resident [redacted] stated "when you are not here they lock me in my room".

The home did not report the resident's claims of abuse from staff to the Department's regional office.

Resident [redacted] was prescribed Probiotic Cap, 1 cap by mouth twice daily for 7 days, beginning 3/6/25. The medication administration record (MAR) indicates the medication was not administered starting on 3/6/25 and continuing through 3/13/25. The MAR indicates the 7 day dosage of the medication was never available in the medication cart to be administered.
Resident [redacted] has an order for [redacted], one tablet nightly at bedtime. The MAR indicates that the medication was not administered from 3/2/25 to 3/7/25. Nursing notes indicate that the medication was not available to administer on those dates.
The home did not report these medication errors to the department's regional office as required.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] 05/02/2025)***

On 4/3/2025 all staff was reducated on the importance of completing a timely report of any allegations and presented with a "Med Tech Survival Guide, a page is the guide is: "ALLEGATIONS: Any allegations by a Resident must be reported to the administrator immediately. Whether believable or not, so that the state can be notified. Please do make sure you document them in PCC and notify Administror or Designee immediately (i.e. someone stole my cell phone, but it was found in their nightstand), it still has to be reported.
Police were dispactched the community and found no incidents of concern (see attached police report)
As part of the "Med Tech Survival Guide" staff were educated "MEDICATION NOT AVAILABLE:
Please Read and follow carefully the information and instructions in this education.
If a medication that is due to be administered is not available, YOU MUST do the following:
1. Check to see if med is available for a future date for same resident.
if available, administer meds and then notify pharmacy to send replacement dose(s)
2. If NOT available in cart, call pharmacy and request medication be sent ASAP (stat drop off/next pharmacy run) & ask if it is available in the cubex
3. Notify MD of delay in medication, document in progress notes what steps were taken, pharmacy's response, and which MD was notified (include dates/times).
4. Call POA/responsible party to update on med not available and steps taken.
5. Document on 24 hour report & notify next shift.
6. In such cases as a missed seizure med or Antihypertensive or Cardiac med, the resident may need to be on alert charting, have VS taken, Neuro checks initiated, etc. call the nurse in HCC for direction.
7. Generate an incident report: this is a medication error {either missed dose, wrong time, wrong drug, etc} If it turns out that there was no actual error after all b/c of your timely interventions, then the incident report will be closed out with that notation.
Writing "ordered" or "med not available" or "medication not in Talis pack"
ETC is not ever enough or appropriate. Here is a sample of what is acceptable:
Name of Medication: [redacted] 1tab q12hrs for seizures

16c Written Incident Report (continued)

"Med not available in cart at this time. Cubex was checked and does not stock medication. Pharmacy called and this (Name of the person) from phoebe pharmacy. [redacted] " stated medication will be stat run out to facility and should arrive by 1800. MD called and notified of projected arrival time. New order to change times (fron nurse in HCC) moving forward of medication administration. Order must be faxed or give to nurse in HCC. Notify POA.
MTs who continue to document inappropriately will be subject to the progressive disciplinary action.
Any Questions? See Administor or [redacted] "
Audits of medications avaiable for administration will be completed by PCHA / Designee monthly x 3 months to ensure they have been appropriately reporting any allegation. Results of audits will be reported to QAA Committee.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented [redacted] - 05/12/2025)

187c - Refusal of Medication

3. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [redacted] resident [redacted] refused the following prescribed medications at 8:00 p.m:

[redacted], and [redacted]. The home did not report the refusal of these medications to the prescriber within 24 hours as required.

Plan of Correction ***Accept ([redacted] - 05/02/2025)***

On 4/3/2025 all staff was reducated on the importance of reporting refused medications to PCP and presented with a "Med Tech Survival Guide", a page in the guide states "write a note for the refusal and since no supervisor is on the attached form must be completed and faxed to MD.
Audits of refused medications will be completed by PCHA / Designee monthly x 3 months to ensure they have been appropriately reporting any allegation. Results of audits will be reported to QAA Committee.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented ([redacted] 05/12/2025)

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

Resident [redacted] was prescribed [redacted], 1 cap by mouth twice daily for 7 days, beginning [redacted]. The medication administration record (MAR) indicates the medication was not administered starting on [redacted] and continuing through [redacted]. The MAR indicates the 7 day dosage of the medication was never available in the medication cart to be administered.

187d - Follow Prescriber's Orders (continued)

Resident [redacted] has an order for [redacted] one tablet nightly at bedtime. The MAR indicates that the medication was not administered from [redacted] to [redacted] Nursing notes indicate that the medication was not available to administer on those dates.

Repeat violation: [redacted]

Plan of Correction ***Accept ([redacted] - 05/02/2025)***

On 4/3/2025 As part of the Med Tech Survival Guide staff were educated "MEDICATION NOT AVAILABLE:
Please Read and follow carefully the information and instructions in this education.
If a medication that is due to be administered is not available, YOU MUST do the following:
1. Check to see if med is available for a future date for same resident.
- if available, administer meds and then notify pharmacy to send replacement dose(s)
2. If NOT available in cart, call pharmacy and request medication be sent ASAP (stat drop off/next pharmacy run) & ask if it is available in the cubex
3. Notify MD of delay in medication, document in progress notes what steps were taken, pharmacy's response, and which MD was notified (include dates/times).
4. Call POA/responsible party to update on med not available and steps taken.
5. Document on 24 hour report & notify next shift.
6. In such cases as a missed seizure med or Antihypertensive or Cardiac med, the resident may need to be on alert charting, have VS taken, Neuro checks initiated, etc. call the nurse in HCC for direction.
7. Generate an incident report: this is a medication error {either missed dose, wrong time, wrong drug, etc} If it turns out that there was no actual error after all b/c of your timely interventions, then the incident report will be closed out with that notation.
Writing "ordered" or "med not available" or "medication not in Talis pack"
ETC is not ever enough or appropriate. Here is a sample of what is acceptable:
Name of Medication: [redacted] 1tab q12hrs for seizures
"Med not available in cart at this time. Cubex was checked and does not stock medication. Pharmacy called and this (Name of the person)_from phoebe pharmacy. [redacted] stated medication will be stat run out to facility and should arrive by 1800. MD called and notified of projected arrival time. New order to change times moving forward of medication administration. Order must be faxed or give to nurse in HCC. Notify POA.
MTs who continue to document inappropriately will be subject to the progressive disciplinary action.
Any Questions? See Administrator or Designee."
Administrator or designee will Report medication errors in a timely manner after investigation is complete to find out why the medication was not availalble.
Audits of medications available for administration will be completed by PCHA / Designee monthly x 3 months to ensure they have been appropriately reporting any allegation. Results of audits will be reported to QAA Committee.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented ([redacted] - 05/13/2025)

188b - Medication Error Reporting

5. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident was prescribed 1 cap by mouth twice daily for 7 days, beginning . The medication administration record (MAR) indicates the medication was not administered starting on and continuing through . The MAR indicates the 7 day dosage of the medication was never available in the medication cart to be administered.

Resident has an order for , one tablet nightly at bedtime. The MAR indicates that the medication was not administered from to . Nursing notes indicate that the medication was not available to administer on those dates.

The home did not notify the prescriber of the medication errors that occurred on these dates as required.

Plan of Correction — ***Accept - 05/02/2025)***

On 4.3.2025, as part of the "Med Tech Survival Guide" staff were educated "MEDICATION NOT AVAILABLE:
Please Read and follow carefully the information and instructions in this education.
If a medication that is due to be administered is not available, YOU MUST do the following:
1. Check to see if med is available for a future date for same resident.
- if available, administer meds and then notify pharmacy to send replacement dose(s)
2. If NOT available in cart, call pharmacy and request medication be sent ASAP (stat drop off/next pharmacy run) & ask if it is available in the cubex
3. Notify MD of delay in medication, document in progress notes what steps were taken, pharmacy's response, and which MD was notified (include dates/times).
4. Call POA/responsible party to update on med not available and steps taken.
5. Document on 24 hour report & notify next shift.
6. In such cases as a missed seizure med or Antihypertensive or Cardiac med, the resident may need to be on alert charting, have VS taken, Neuro checks initiated, etc. call the nurse in HCC for direction.
7. Generate an incident report: this is a medication error {either missed dose, wrong time, wrong drug, etc} If it turns out that there was no actual error after all b/c of your timely interventions, then the incident report will be closed out with that notation.
Writing "ordered" or "med not available" or "medication not in Talis pack"
ETC is not ever enough or appropriate. Here is a sample of what is acceptable:
Name of Medication: tab 1tab q12hrs for seizures
"Med not available in cart at this time. Cubex was checked and does not stock medication. Pharmacy called and this (Name of the person)_from phoebe pharmacy. "Mike" stated medication will be stat run out to facility and should arrive by 1800. MD called and notified of projected arrival time. New order to change times moving forward of medication administration. Order must be faxed or give to nurse in HCC. Notify POA.
MTs who continue to document inappropriately will be subject to the progressive disciplinary action.
Any Questions? See or ."
Audits of medications available for administration will be completed by PCHA / Designee monthly x 3 months to ensure they have been appropriately reporting any allegation. Results of audits will be reported to QAA Committee.

Licensee's Proposed Overall Completion Date: *04/24/2025*

188b Medication Error Reporting *(continued)*

Implemented (CP - 05/13/2025)

225c Additional Assessment

6. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted] has frequent [redacted] and [redacted] behaviors. Nursing notes for resident [redacted] indicate that resident [redacted] frequently accuses staff of various things such as abuse, stealing, preventing the resident from leaving the home, and poisoning them. The support plan for resident [redacted] dated [redacted] was not updated with these behaviors and with a plan to address these behaviors. The behavioral and Cognitive needs section of the support plan indicates "Not Applicable" for these types of behaviors.

Repeat violation: [redacted].

Plan of Correction ***Accept [redacted] 05/02/2025)***

On 4/3/2025 staff was reeducated on documenting and reporting all behaviors of Resident. RASP as been updated to show continued behaviors. (see attached) Audits of behaviors will be completed by PCHA / Designee monthly x 3 months to ensure they have been appropriately prescribed starting

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented [redacted] - 05/13/2025)