pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [bwalling@asbury.org]

MAILING DATE: April 30, 2020

Mr. Brian D. Grundusky
Executive Director
Asbury Atlantic
5285 Westview Drive, #200
Frederick, Maryland 21703

RE: Bethany Village Retirement Center
5225 Wilson Lane
Mechanicsburg, Pennsylvania 17055
Certificate #: 330230

Dear Mr. Grundusky:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living) review on January 28 and 29, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Gloria Emick

Gloria Emick
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *BETHANY VILLAGE RETIREMENT CENTER* **License Number**: *33023*
Address: *5225 WILSON LANE, MECHANICSBURG, PA 17055*
County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

Name: *Bridget Walling* **Phone**: *7175918091* **Email**: *BGRUNDUSKY@ASBURY.ORG*

Legal Entity

Name: *ASBURY ATLANTIC*
Address: *5285 WESTVIEW DR, 200, FREDERICKN, MD, 21703*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/27/2005* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *125* **Waking Staff**: *94*

Inspection

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

Inspection Dates and Department Representative

01/28/2020 - On-Site: Douglas Hoover, Dale Rosenblat

01/29/2020 - On-Site: Douglas Hoover, Dale Rosenblat

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *96*

Special Care Unit

In Home: *Yes* **Area**: *Golden Maple* **Capacity**: *30* **Residents Served**: *29*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *96*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *29* **Have Physical Disability**: *0*

183d Current medications

Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 1/29/2020, there was a partially-used vial of Novolog insulin that belonged to Resident #1 stored in the 2nd floor medication room refrigerator. Manufacturer guidelines require that the insulin be discarded 28 days after opening. The insulin was first used on 11/29/2019.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Upon discovery of the expired medication on January 29, 2020, the medication was immediately discarded in the proper receptacle by the Director of Clinical Services (DOCS). Furthermore, on January 29, 2020 all other medication refrigerators were audited for any expired medications by the DOCS. Daily audits continued and LPN education was provided by the DOCS on February 12, 2020. Medication refrigerators will be checked daily by the 11pm-7am LPN on duty each night to ensure no expired medications are present. Documentation will be noted on a monthly log sheet that was created by the Administrator. The DOCS will audit the logs monthly. Attached document #1 is the log.

Revised Plan-

On January 29th, 2020, 3 medication refrigerators were audited. 6 vials of insulin and 1 insulin pen were audited and were all current. No other expired medications were discovered during the audit. Daily audits for expired medications was completed by the 11-7am LPN's. Education for all LPN's, as well as the updated audit log was provided by February 12, 2020. As of April 27, 2020, the audit worksheet has been revised to include the number of insulin vials/insulin pens audited, as well as, the status and indication to notify DOCS/Administrator immediately.

Attached documentation- #1 Updated Refrigerator Temperature/Expired Medication Log, #2 Completed Medication Refrigerator Temperature Log forms, #3 Email communication regarding new Refrigerator Temp Logs

Legal Entity Representative

Bridget Walling — Signature

Bridget Walling Administrator — Printed Name and Title

4/29/20 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 4/29/20 (Date)

The above plan of correction was approved by GE (Initials)

Plan of correction implementation status as of 4/29/20 (Date)

XX Implemented

☐ Not Implemented

187d Follow prescriber's orders

Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Lumify, 0.025% eye drops were not administered on 1/18/2020 at 6:00 am and 4:00 pm for Resident #2 because the facility did not have the medication.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On January 29, 2020 immediate confirmation was received by the Director of Clinical Services (DOCS) that the resident was currently receiving the prescribed medication without delay. January 30, 2020-February 5, 2020 the DOCS and AL Administrator communicated directly with LPN staff face-to-face and via email to educate regarding the requirement to follow physicians orders. Staff education provided instruction of how to obtain medications when needed. The DOCS will perform random audits to ensure all medications are administered as ordered by the physician. On February 11, 2020 the LPN orientation checklist was updated by the Clinical Scheduler and Administrator, to include the "Process to avoid missed/unavailable medication". The orientation log will be collected, and audited prior to the LPN working independently by the Clinical Scheduler. Attached document #2 is the revised LPN Orientation Checklist.

Revised Plan-
On January 30, 2020 confirmation from the Medicine Shoppe indicated that the refill order was received on 1/18/20 and the medication was delivered the night of 1/18/20. The core issue identified indicted that the licensed staff did not request immediate delivery of the medication. Our expectation would be that licensed staff request immediate delivery of any medication in the event it is identified as not available, in this case empty. Both the 7-3 and 3-11pm staff members received verbal education regarding the process to obtain medications at any time. Random audits have been completed monthly and will be ongoing.
Attached documentation- #4 email communication with nursing staff regarding reordering process and expectation, #5 Documentation of random audits completed by DOCS.

Legal Entity Representative

Bridget Walling — Signature

Bridget Walling Administrator — Printed Name and Title

4/29/20 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 4/29/20 (Date)

The above plan of correction was approved by GE (Initials)

Plan of correction implementation status as of 4/29/20 (Date)

XX Implemented
Not Implemented

236a Staff training

Requirements

2800.
236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct Care Staff Members A, B, C and D; hired 7/9/2019, 3/18/2019, 4/29/2019 and 8/9/2017 respectively, did not have 8 hours of dementia training within the first 30 days of their date of hire.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

In August 2019, prior to the 2020 annual survey completed by DHS, it was discovered by the clinical scheduler, that staff members A, B, and C, had not completed the required 8 hours of dementia training within the first 30 days of their hire date. Immediately, the clinical scheduler and AL Administrator developed a tracking log to ensure completion of the required dementia training to be completed within the first 30 days of any new staffs hire date. The clinical scheduler will maintain this document and track compliance. Attached is document #3 (tracking tool developed in 2019 at the discovery.)

Revised plan -
In August 2019 the clinical scheduler was terminated from her position at Bethany Village, at that time a record review was completed and it was discovered the 3 mentioned associates had not completed the 8 hours of dementia training within the first 30 days.
Attached Documentation- #6 proof of training for associates A, B, and C. #7 Documentation indicating new hire 8 hour dementia training completed within first 30 days

Legal Entity Representative

Bridget Walling — Signature

Bridget Walling Administrator — Printed Name and Title

4/29/20 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 4/29/20 (Date)

The above plan of correction was approved by GE (Initials)

Plan of correction implementation status as of 4/29/20 (Date)

XX Implemented

☐ Not Implemented