



July 6, 2020

Mr. Philip G. DeBaun
Chief Executive Officer
Foulkeways at Gwynedd
1120 Meeting House Road
Gwynedd, PA 19436

RE: Foulkeways at Gwynedd
License #: 127740

Dear Mr. DeBaun:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 13 and 14, 2019 and August 8, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink that reads "Jamie L. Buchenauer". The signature is written in a cursive style.

Jamie L. Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: FOULKEWAYS AT GWYNEDD

License Number: 127740

Address: 1120 MEETING HOUSE ROAD, GWYNEDD, PA 19436

County: MONTGOMERY

Region: SOUTHEAST

Administrator

Name: Cassandra Sheard and Faith Lucas Phone: 2156432200

Email: Mary_Knapp@FOULKEWAYS.ORG

Legal Entity

Name: FOULKEWAYS AT GWYNEDD

Address: 1120 MEETING HOUSE ROAD, PA, 19436

Certificate(s) of Occupancy

Type: C-2 LP

Date: 06/14/2004

Issued By: L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 85

Waking Staff: 64

Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal

Inspection Dates and Department Representative

05/13/2019 - On-Site: Youn Hie Chung, Jennie Heinberg

05/14/2019 - On-Site: Youn Hie Chung, Jennie Heinberg

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 112

Residents Served: 78

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 78

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 7

Have Physical Disability: 7

5a1 - DHS Access

Regulations

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On 05/13/2019, at 11:30 AM, licensing representatives requested annual staff training records for training year August 2017~July 2018 for selected staff but the home failed to provide this information until 02:30 PM on 05/14/2019.

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.)

SEE ATTACHED

Please see attached.....

Legal Entity Representative

Mary T Kwapp

Signature

MARY T KWAPP / DIR HEALTH SERVICES
6/28/19

Printed Name and Title

Date

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

The above plan of correction is approved as of

07-02-20
(Date)

Plan of correction implementation status as of

07-02-20
(Date)

The above plan of correction was approved by

SP
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - inadequate Progress
- Not Implemented

2600 5.a

We dispute this violation.

When the Agents of the Department arrived on May 13, 2019, they requested a list of Personal Care employees. That was provided by that arrival morning. The Agents selected staff records based on the list provided. Training records for the selected staff were provided that afternoon.

On May 14, 2019 we were informed the training records were not adequate. We sat with the Agents and discussed what was needed. We then presented additional materials to the Agents by 2:30 PM on May 14, 2019.

We provided immediate access to training records, the Agents continued to ask for additional records during the survey. We did provide immediate access to records that we thought were adequate, the same records that have been adequate during past surveys, they were not according to the DHS Agents, we continued to work with the Agents.

DPOC – Administrator or designee will ensure there is always a staff member on hand who can provide immediate access to the home, residents, and records to agents of the Department when requested in accordance with regulation 2600.5a. Requested documents shall be provided in a timely manner.

SP 07-02-2020

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

There is no carbon monoxide detector within 15 feet of the boiler room in the home's basement. The boiler is gas operated.

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.)

SEE ATTACHED

Legal Entity Representative

Mary T Knapp
Signature

MARY T KNAPP / BIR HEALTH SERVICES
Printed Name and Title

Date
6/28/2019

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2600.18

We dispute this violation

According to our Fire Safety Inspector this boiler is in a "not regulated out building" (the Community Center) that does not required a carbon monoxide detector.

We added a carbon monoxide detector on 5/23/2019 as a best practice but we do not deserve a violation

DPOC – Administrator or designee will ensure there is a carbon monoxide detector placed within 15 feet of all fossil fuel burning appliances.

SP 07-02-2020

25b - Contract Signatures

Regulations

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated 08/20/2018, for resident #1 was not signed by the resident.

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.)

SEE ATTACHED

Legal Entity Representative

Mary J Knapp
Signature

MARY J KNAPP / DIR HEALTH SERVICES
6/28/19
Printed Name and Title
Date

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2600 25.b

We dispute this violation

The official resident-home contract was signed by the Foulkeways at Gwynedd administrator and the Resident's POA who was acting on the Resident's legal behalf to sign legal documents. The Resident selected the POA prior to entering the Personal Care Home to act on his behalf if unable to make decisions.

See attached.

DPOC – Administrator or designee will ensure resident/home contract is signed by all parties indicated in regulation 2600.25b. If resident is unable to sign contract, home will indicate resident unable or refusal to sign.

SP 07-02-2020

41e - Signed Statement

Regulations

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

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.)

SEE ATTACHED

Legal Entity Representative

Mary Knapp
Signature

MARY KNAPP / DIR. HEALTH SERVICES
6/28/19
Printed Name and Title
Date

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2600 41 e

Actions to Correct the Violation/Specific Changes: The Resident's POA signed the contract which contained the Resident's Rights but not the complaint procedures. (See attachment) The current Personal Care contract is being revised to contain both Residents Rights and Complaint procedures.

The complaint procedure will be given to the POA and resident and a receipt will be obtained by July 15, 2019

Who will make the changes: Mary Knapp, Director of Health Services will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding acknowledging receipt of a copy of the Residents Rights and complaint procedure
- Policy and procedure reviews and revisions, if necessary

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Current contract that does not contain the Residents Rights and Complaint procedure will be discarded

Training of Staff:

- Staff will be oriented and trained on new contract.

65e - 12 Hours Annual Training

Regulations

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

- 1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
- 2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

The home could not provide the total number of hours of annual training for direct care staff member A in training year August 2017 through July 2018.

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.)

SEE ATTACHED

Legal Entity Representative

Mary T Knapp

Signature

MARY T KNAPP / DIR HEALTH SERVICES

Printed Name and Title

Date
6/28/2019

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2600 65e

We dispute this violation

Employee A resigned before he could complete his annual 12 hours of training in training year August 2017 through July 2018. (See attached termination form)

Employee A did complete 7.5 hours of training which was documented (See attached)

DPOC – Administrator or designee will ensure all direct care staff workers have 12 hours of annual job training related to their duties in accordance with 2600.65e. A training list will be developed to account for topic trained on and hours spent. Annual staff training to be maintained by home and made available for Department review.

SP 07-02-2020

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 1. Medication self-administration training.

Description of Violation

Direct care staff person A did not receive training in medication self-administration during training year August 2017 through July 2018.

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.)

SEE ATTACHED

Legal Entity Representative

Signature 

Printed Name and Title **MARY T KNAPP / DIR. HEALTH SERVICES**
 Date **6/28/19**

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2600 65 f

We dispute this violation

Employee A resigned before he could complete his annual medication self-administration training in training year August 2017 through July 2018.

See attached termination form

DPOC – Administrator or designee will ensure all direct care staff workers have medication administration training in accordance with 2600.65f. A training list will be developed to account for topics trained on and hours spent. Annual staff training to be maintained by home and made available for Department review.

SP 07-02-2020

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- 3. Resident rights.

Description of Violation

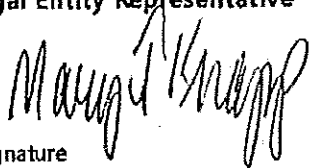
Staff person A did not receive training in Resident Rights during training year August 2017 to July 2018.

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.)

SEE ATTACHED

Legal Entity Representative


Signature

MARY T KNAPP / DIR HEALTH SERVICES
4/28/19
Date

Printed Name and Title

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2600 65 g

We dispute this violation

Employee A was trained in Residents Rights in training year August 2017 through July 2018.

See attached sign in form and records

DPOC – Administrator or designee will ensure all direct care staff workers have residents rights training in accordance with 2600.65g. A training list will be developed to account for topics trained on and hours spent. Annual staff training to be maintained by home and made available for Department review.

SP 07-02-2020

65i - Training Record

Regulations

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training does not include the length of each course.

Plan of Correction (POC)

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SEE ATTACHED

Legal Entity Representative

Mary P. Mapp
Signature

MARY P. MAPP / DIR HEALTH SERVICES
Printed Name and Title

6/28/19
Date

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2600 65 i

We dispute this violation

We have two sources of training to meet annual training requirements.

1. Training Day which includes 7.5 hours of training for all staff. Each employee receives a certificate like the one attached, the hours are listed on the back of the certificate
2. Relias computer training, the hours of training are recorded and documented in the software, a sample of the Relias form is attached

These hours were provided to the DHS agents

See attached sign in form and records

DPOC – Administrator or designee will ensure A training list will be developed to account for staff person trained, date, source, content, length of each course, and copies of any certificates received in accordance with regulation 2600.65i. Annual staff training to be maintained by home and made available for Department review.

SP 07-02-2020

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 05/14/2019 at 11:20 AM, there was a glucometer with a label saying 'stock glucometer for temporary resident use' and there were several readings on it. The staff on duty said that they use it and clean it with Super-Sani Cloth.

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.)

SEE ATTACHED

Legal Entity Representative

Mary A Knapp
Signature

MARY KNAPP / DIR OF HEALTH SERVICES
Printed Name and Title
6/28/19 Date

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2600 85 a

Actions to Correct the Violation/Specific Changes: The glucometer in question was removed and discarded on May 14, 2019. Only Resident specific glucometers are presently in the Personal Care Home and this practice will continue.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the use of glucometers and sanitary methods
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services and Maryann Gross, Director of Nursing.

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding sanitary care of glucometers
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

101j5 - Bedside Table/Shelf

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside the resident's bed in resident room #308.

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.)

SEE ATTACHED

Legal Entity Representative

Mary J Knapp
Signature

MARY J KNAPP / DIR HEALTH SERVICES
Printed Name and Title

6/28/19
Date

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2600 101j5

We dispute this violation

This Resident's apartment # 308, was furnished by him in a manner that he chooses. The DHS Agents never spoke with the Resident regarding how he wanted his bedroom to be furnished.

If they had spoken with him or observed the room set up, they would have realized there is a bedside table by his bed where he sleeps. His wife died, the twin bed where she sleep has no bedside table based on the Resident's wishes

See attached letter

DPOC – Administrator or designee will ensure all residents have a bedside table or shelf in their bedroom in accordance with regulation 2600.101j5. if the resident indicates they don't wish to have a table or shelf at bedside, it's mandatory for the home to request/receive a waiver. Audit of all bedrooms to be completed to ensure compliance is met.

SP 07-02-2020

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident bedrooms #53, #103, and #305 do not have a source of light that can be turned on/off at bedside.

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.)

SEE ATTACHED

Legal Entity Representative

Signature *Mary T Knapp*

Printed Name and Title *MARY T KNAPP / DIR HEALTH SERVICES*
 Date *4/28/2019*

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2600 101 J7

We dispute this violation

Apartment #53 The Resident has lived in personal Care since 12/12/13 he does not want a bedside lamp or source of lighting, he never did, and we confirmed and documented this in his record

Apartment #305 The Resident has a purple bedside lamp at the time of inspection and it remains in her apartment

Apartment # 103 The Resident/wife do not want a bedside lamp or light source, they leave the overhead or bathroom light on.

In none of these cases did the DHA agent speak with the Residents about their personal preferences

DPOC – Administrator or designee will ensure all residents have an operable lamp or other source of lighting that can be turned off at bedside in accordance with regulation 2600.101j7. if the resident indicates they don't wish to have an operable lamp or source of lighting at bedside , it's mandatory for the home to request/receive a waiver. Audit of all bedrooms to be completed to ensure compliance is met.

SP 07-02-2020

107d - Procedure Emergency Management Agency Submission

Regulations

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 2015.

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.)

SEE ATTACHED

Legal Entity Representative

Mary J Knapp
Signature

MARY J KNAPP / DIR HEALTH SERVICES
Printed Name and Title

Date
6/28/19

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2600 107.d

Actions to Correct the Violation/Specific Changes: The home's emergency procedures are being updated and will be sent to the local emergency management agency by July 30, 2019.

Who will make the changes: Mary Knapp, Director of Health Services

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Policy has been revised so that emergency procedures are reviewed, updated and submitted annually to the local emergency management agency.

Training of Staff:

- Initially inservices will be provided with appropriate staff.

123b - Emergency Procedures Posted

Regulations

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 (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.)

SEE ATTACHED

Legal Entity Representative

Signature *Mary J Knapp*

Printed Name and Title *MARY J KNAPP / DIR HEALTH SERVICES*

Date *6/28/19*

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2600 123.b

We dispute this violation

The manual that contains our emergency preparedness is posted in a conspicuous and public place on a shelf outside the Main Personal Care dining room and it is labeled. It is the same place that previous DHS agents have observed during survey.

DPOC – Administrator or designee will ensure copies of the emergency procedures are posted in a conspicuous place in the home.

SP 07-02-2020

141a - Medical Evaluation

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #2 was admitted to the home on 04/11/2019. Her medical evaluation was completed on 05/29/2019.

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.)

SEE ATTACHED

Legal Entity Representative

Mary T Knapp
Signature

MARY T KNAPP / DIR HEALYH SERVICES

Printed Name and Title

6/28/19
Date

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2600 141 a

Actions to Correct the Violation/Specific Changes: We are unable to change the 5/29/2019 DME for Resident #2. The current DME was completed on 4/2/2019 which is within the annual completion timeframe. All Admission DMEs will be completed 60 days prior to admission or within 30 days after admission.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the use of glucometers and sanitary methods
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services, Maryann Gross, Director of Nursing, Physicians and Certified Registered Nurse Practitioners

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Physicians and Certified Registered Nurse Practitioners will receive re-education by Mary Knapp, Director of Health Services

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation dated 08/23/2018 did not include #4, 5, 7, 8, 9, or 10.

Resident #3's medical evaluation dated 05/08/2018 did not include #10.

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.)

SEE ATTACHED

Legal Entity Representative

Mary Knapp
Signature

MARY KNAPP / AIR HEALTH SERVICES

Printed Name and Title

6/28/19 Date

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SP
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600 141 a #2

Actions to Correct the Violation/Specific Changes: All DMEs have been updated as of June 28, 2019 by the Personal Care Co-Managers following regulatory guidelines.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the completion of DMEs
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services, Maryann Gross, Director of Nursing, Physicians and Certified Registered Nurse Practitioners

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Physicians and Certified Registered Nurse Practitioners will receive re-education by Mary Knapp, Director of Health Services

141b1 - Annual Medical Evaluation

Regulations

2600.

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

Description of Violation

Resident #4's most recent medical evaluation was completed on 05/14/2018. The resident's previous medical evaluation was completed on 01/24/2017.

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.)

SEE ATTACHED

Legal Entity Representative

Mary T Knapp
Signature

MARY T KNAPP / DIR. HEALTH SERVICES
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- Not Implemented

2600 141 b.1

Actions to Correct the Violation/Specific Changes: We are unable to change the 5/14/2019 DME. The next annual DME will be completed by 5/14/2020 which is within the annual completion timeframe. All DMEs will be completed annually.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the use of glucometers and sanitary methods
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services, Maryann Gross, Director of Nursing, Physicians and Certified Registered Nurse Practitioners

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Physicians and Certified Registered Nurse Practitioners will receive re-education by Mary Knapp, Director of Health Services

183d - Prescription Current

Regulations

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 05/14/2019, at 10:30 AM, following discontinued medications for several residents were still in the home's med cart:

Santyl Ointment 250 mg (for wound care; wound was healed and no longer needed) and Deborax 6.5% solution (ordered on 01/23/2019 for 7 days) for resident #1

Deborax 6.5% Solution discontinued on 04/26/2019 for resident #5

Acetaminophen 325 mg (ordered on 11/01/2018 for 14 days) and Sulfacetamide Sodium 10% eye drops (ordered on 10/10/2018 for 7 days) for resident #6

Acetaminophen 325 mg for resident #7 (not a current order)

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.)

SEE ATTACHMENTS

Legal Entity Representative

Mary T Knapp
Signature

MARY T KNAPP / DIR HEALTH SERVICES

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- Not Implemented

2600-183.d

Actions to Correct the Violation/Specific Changes: All discontinued medications were removed and destroyed on 5/14/2019. Only current prescription, OTC, sample and CAM for individuals living in the home will be kept in the home.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding current medication storage
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services, Maryann Gross, Director of Nursing and the Pharmacist

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding current medication storage
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

185a - Implement Storage Procedures

Regulations

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 05/14/2019, the glucometer for resident #1 had no label on it and was not calibrated to correct date and time.

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.)

SEE ATTACHED

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- Not Implemented

2600 185.a

Actions to Correct the Violation/Specific Changes: The glucometer was labeled and recalibrated on 5/14/2019. All Medications and medical equipment will have safe storage, access, security, distribution and use.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the use of glucometers and sanitary methods
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services, Maryann Gross, Director of Nursing.

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding glucometers
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

- 12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #4 is prescribed Isosorbide MN ER 90 mg and Metoprolol Tartrate 25 mg. However, his medication administration record does not indicate the diagnoses for these meds.

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.)

SEE ATTACHED

Legal Entity Representative

Mary G Knapp
Signature

MARYT KNAPP / DIR. HEALTH SERVICES
Printed Name and Title

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2600 187.a

Actions to Correct the Violation/Specific Changes: The diagnoses were added to the Physician Order form by the Certified Nurse Practitioner on June 27, 2019. All medications will have a diagnosis listed

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding diagnoses for all medications
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services, Maryann Gross, Director of Nursing, Pharmacist, Physicians and Certified Registered Nurse Practitioners

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Physicians and Certified Registered Nurse Practitioners will receive re-education by Mary Knapp, Director of Health Services

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 05/14/2019 around 10:30 AM, staff B was witnessed entering her signatures for all the residents whom she administered morning medications. She did not enter her signature at the time she administered the medications.

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.)

SEE ATTACHED

Legal Entity Representative

Signature *Mary T Knapp*

MARY T KNAPP / DIR HEALTH SERVICES

Printed Name and Title

Date *6/28/2019*

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2600 187b

Actions to Correct the Violation/Specific Changes: The RN was counseled on May 14, 2019 regarding proper recording of medication administration. All staff will properly record medication administration.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the use of glucometers and sanitary methods
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services and Maryann Gross, Director of Nursing

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding medication administration
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

187c - Refusal of Medication

Regulations

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 05/08/2019 at 09:00 AM, resident #8 refused to take a scheduled dose of Azithromycin 250 mg, Linezolid 600 mg, and Vitamin D3 5,000 Units. The home did not notify the prescriber of the refusal.

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.)

SEE ATTACHEES

Legal Entity Representative

Mary J Knapp

Signature

MARY TRUAPP / DIR HEALTH SERVICES

Printed Name and Title

Date

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- Not Implemented

2600 187 c

Actions to Correct the Violation/Specific Changes: When Residents refuses medications the Prescriber will be notified within 24 hours or according to prescriber's instructions.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding Resident refusal of medications
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services and Maryann Gross, Director of Nursing

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding resident refusal to take medications
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #5 was ordered a vital sign check daily for a week. However, her vital signs were checked only 2 days that week on 05/04/2019 and 05/06/2019.

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.)

SEE ATTACHED

Legal Entity Representative

Mary A Knapp
Signature

MARYT KNAPP / DIR. HEALTH SERVICES
Printed Name and Title

Date

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2600 187.d

Actions to Correct the Violation/Specific Changes: All directions made by the prescriber will be followed

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding Prescriber orders
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services and Maryann Gross, Director of Nursing

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding prescriber orders
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted 08/20/2018, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

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.)

SEE ATTACHED

Legal Entity Representative

Mary T Knapp

Signature

MARY T KNAPP / BIR HEALTH SERVICES

Printed Name and Title

Date

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2600 191

We are disputing this violation

The Resident was educated on the Right to Refuse medications

See Attached

DPOC – Administrator or designee will ensure all residents are educated to their rights to refuse medication in accordance with regulation 2600.191

SP 07-02-2020

224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #9's preadmission screening form, dated 12/11/2018, does not include Personal Care and Medical Needs.

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.)

SEE ATTACHED

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Mary J Knapp

Signature

MARY J KNAPP / DIR HEALTH SERVICES

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2600 224.a

We are disputing this violation

The Resident had NO Personal Care or Medical Needs listed on the preadmission screening form because they had no personal care or medical needs, therefore, nothing was checked off

See Attached

DPOC – Administrator or designee will ensure all preadmission screening forms are completed timely and accurately in accordance with regulation 2600.224a

SP 07-02-2020

225c - Additional Assessment

Regulations

2600.

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

- 1. Annually.

Description of Violation

Resident #4's most recent assessment was completed on 02/03/2018.

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.)

SEE ATTACHED

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2600 225.c

Actions to Correct the Violation/Specific Changes: Resident #4's annual RASP assessment was completed on May 15, 2019. It was reviewed with the Resident. All RASPS will be completed in a timely manner. .

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the use of glucometers and sanitary methods
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services and Maryann Gross, Director of Nursing.

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding RASP completion
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

227a - Support Plan 30 Days

Regulations

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on 08/20/2018; however, the resident's initial support plan finalization date is missing, which makes it impossible to determine if it was completed/timely.

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.)

SEE ATTACHED

Legal Entity Representative

Mary A Knapp

Signature

MARY A KNAPP / DIR HEALTH SERVICES

Printed Name and Title

Date

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- Not Implemented

2600 227.a

Actions to Correct the Violation/Specific Changes: We cannot determine the date of the completion of support plan. In the future all support plans will be properly dated.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the proper dating of support plans
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services and Maryann Gross, Director of Nursing.

Changes will be completed by: July 30, 2019

System to prevent future violations:

- Monitoring and audits of changes through 2019 by the Personal Care Co- Managers
- Daily observation of staff by the Co-Managers and their designees regarding proper dating of support plans
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

- Initially inservices will be provided with appropriate staff on all three shifts/7 days a week regarding
- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

227c - Support Plan Revision

Regulations

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #4's assessment was not completed annually nor was the resident's support plan revised annually.

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.)

SEE ATTACHED

Legal Entity Representative

Mary J Knapp
Signature

MARY J KNAPP / DIR HEALTH SERVICES
Printed Name and Title

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2600 227.c

Actions to Correct the Violation/Specific Changes: Resident #4's annual RASP assessment was completed on May 15, 2019. It was reviewed with the Resident. All RASPS will be completed in a timely manner.

Who will make the changes: Foulkeways at Gwynedd Personal Care Co-Managers, Faith Lucas, LPN and Sandy Shread, LPN will be responsible for the changes noted above including:

- Orientation of new staff
- Current staff education/re-education regarding the use of glucometers and sanitary methods
- Policy and procedure reviews and revisions, if necessary
- Day to day oversight involved staff regarding changes

The Co-Managers will be supported by Mary Knapp, Director of Health Services and Maryann Gross, Director of Nursing.

Changes will be completed by: July 30, 2019

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- Daily observation of staff by the Co-Managers and their designees regarding RASP completion
- When specific staff member is not in compliance with the changes they will receive 1:1 education, performance counseling and progressive disciplinary actions if necessary.

Training of Staff:

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- Staff will receive reminders during interdisciplinary Resident focused weekly meetings on Tuesdays and Fridays
- Memos will be posted as necessary to remind staff of changes

Violation Report

Facility Information

Name: *FOULKEWAYS AT GWYNEDD*License Number: *12774*Address: *1120 MEETING HOUSE ROAD,, GWYNEDD, PA 19436*County: *MONTGOMERY*Region: *SOUTHEAST*

Administrator

Name: *Mary Knapp*Phone: *2156432200*Email: *ADMINISTRATION@FOULKEWAYS.ORG*

Legal Entity

Name: *FOULKEWAYS AT GWYNEDD*Address: *1120 MEETING HOUSE ROAD, GWYNEDD, PA, 19436*

Certificate(s) of Occupancy

Type: *C-2 LP*Date: *6/14/2004*Issued By: *PA Dept of L&I*

Staffing Hours

Resident Support Staff: *0*Total Daily Staff: *86*Waking Staff: *65*

Inspection

Type: *Partial*

BHA Docket #:

Notice: *Unannounced*Reason: *POC Verification*

Inspection Dates and Department Representative

08/08/2019 - On-Site: David Carrion, Sabrina Freeman

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112*Residents Served: *84*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*Are 60 Years of Age or Older: *84*Diagnosed with Mental Illness: *0*Diagnosed with Intellectual Disability: *0*Have Mobility Need: *2*Have Physical Disability: *2*

FOULKEWAYS AT GWYNEDD

12774

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #1 does not have access to a source of light that can be turned on/off at bedside.

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.)

SEE ATTACHED

Legal Entity Representative

Mary T Knapp

Signature

MARY T KNAPP / DIRECTOR HEALTH SERVICES 9/27/2019

Printed Name and Title

Date

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

The above plan of correction is approved as of 10/30/19
(Date)

Plan of correction implementation status as of 10/30/19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600 101 j

An operable lamp was been placed at the bedside as of August 8, 2019.

All other Resident rooms have been assessed and operable lamps or other source of lighting that can be turned on at bedside is present.

The Personal Care co-managers will make sure lamps or light sources are present on admission of each Resident.

The administrator or designee will conduct bedroom checks at least monthly to ensure lights are available at all bedsides, starting immediately. SP 10/30/19

Mary J Knapp
9/29/2019

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident's #2 and #3 medical evaluations did not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

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Legal Entity Representative

Maryt Knapp

Signature

MARYT KNAPP / DIRECTOR OF HEALTH SERVICES 9/17/19

Printed Name and Title

Date

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2600 141 a 1-10

Resident #2 and #3 have the required information recorded in their record

The Personal Care Co-Managers will insure this information is recorded in all Medical Evaluations by reviewing these documents immediately after they have been completed by the physician and or nurse practitioner on all new admissions.

The Personal Care Co-Manager will conduct an audit of the medical evaluations for all residents by November 30, 2019 and bi-annually thereafter. SP 10/30/19

Mary J Knapp
9/27/2019

FOULKEWAYS AT GWYNEDD

12774

141b1 - Annual Medical Evaluation

Regulations

2600.

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

Description of Violation

Resident #3's most recent medical evaluation was completed on 07/17/19. The resident's previous medical evaluation was completed on 06/11/18.

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2600 141 b.1

We dispute this violation. The regulation states there is to be a medical evaluation at least annually. The medical evaluation was done in 2018 and 2019, this is annually. The regulation does not state every 12 months or at least every 12 months.

All medical evaluations have been audited and are within the annual required timeframe.

The Personal Care co-managers have a list of the due dates for all medical evaluations.

Mary J Knapp
9/29/2019

The administrator will ensure all medical evaluations are completed annually, within 365 days of the previous medical evaluation, starting immediately. Annually is defined as every 365 days and the administrator will develop and implement a tracking tool to assist in ensuring all resident medical evaluations are conducted in accordance with the regulations, by November 30, 2019.

The administrator will schedule an in-service for the staff on the importance of scheduling medical evaluations annually, by November 30, 2019. Documentation of the in-service will be maintained for the Departments review. SP 10/30/19

FOULKEWAYS AT GWYNEDD

12774

183d - Prescription Current

Regulations

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 08/08/19, Acetamiphone 500 mg 2 tabs by mouth 3 times a day for 7 days prescribed for resident #2, was in the home's medication cart ; however, the medication was discontinued on 07/17/19.

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2600 183 d

The "Acetamiphone" was removed from Resident #2 supply on 8/8/2019 although the Resident was still prescribed the medication as a PRN. The medication was re-labeled by the Pharmacy

All discontinued medications will be removed from the Resident's supply when discontinued and sent to the Pharmacy

Discontinued medications will be checked by 11-7 licensed staff each night to insure they have been removed.

The administrator will conduct an in-service to all staff who provide medication administration on the importance of checking resident medications daily and removing discontinued medications by November 30, 2019.

The administrator of designee will conduct medication audits during monthly recaps to ensure all prescribed medications are in the med cart, starting immediately. SP 10/30/19

Mary J Knapp
9/27/2019

FOULKEWAYS AT GWYNEDD

12774

191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted 05/01/19, has not been educated no the resident's right to refuse medication if the resident believes that there may be a medication error.

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2600 191

Resident #2 was educated that he can refuse medications if he believes there may be a medication error.

All Residents have been informed they can refuse a medication for any reason

The administrator or designee will conduct an audit of all resident records to ensure all records include a document to indicate they have the right to refuse a medication if they believe it is in error, by December 30, 2019. SP 10/30/19

Mary J Knapp
9/27/2019

FOULKEWAYS AT GWYNEDD

12774

224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

There is no preadmission screening form for resident #2, admitted 05/01/19.

Resident #4's preadmission screening form, dated 06/07/19, does not include a determination that the needs of the resident can be met by the services provided by the home.

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2600 224.a

The staff that complete pre-admission screen have been re-trained to properly complete the pre-admission screen

Both Residents care needs were properly met

Pre-admission screens will be audited by the Personal Care co-managers when they are conducted to insure accuracy

The administrator will ensure Resident # 2 and #4 pre-admission screening forms are completed as required by the regulations, by November 30, 2019. SP 10/30/19

Mary J Knapp
9/27/2019