pennsylvania
DEPARTMENT OF HUMAN SERVICES

October 10, 2019

Ms. Tara Everhart, RN
Meadowood Corporation
P.O. Box 670
3205 Skippack Pike
Worcester, Pennsylvania 19490

RE: Meadowood
License #: 127870

Dear Ms. Everhart:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 16 and 17, 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,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *MEADOWOOD*

License Number: *127870*

Address: *P O BOX 670 3205 SKIPPACK PIKE, WORCESTER, PA 19490*

County: *MONTGOMERY*

Region: *SOUTHEAST*

Administrator

Name: *Jennifer Eslinger*

Phone: *6105841000*

Email: *TEVERHART@MWOOD.ORG*

Legal Entity

Name: *MEADOWOOD CORPORATION*

Address: *P.O.BOX 670, 3205 SKIPPACK PIKE, WORCESTER, PA, 19490*

Certificate(s) of Occupancy

Type: *C-1*

Date: *10/20/1988*

Issued By: *Commonwealth of PA, DOH*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *57*

Waking Staff: *43*

Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal*

Inspection Dates and Department Representative

05/16/2019 - On-Site: Dean Gray

05/17/2019 - On-Site: Dean Gray

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *76*

Residents Served: *45*

Secured Dementia Care Unit

In Home: *Yes*

Area: *Azalea House*

Capacity: *12*

Residents Served: *12*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *45*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *12*

Have Physical Disability: *0*

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 records do not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Repeat Violation: 09/11/17

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

Stephanie Messler — Signature

Stephanie Messler — Printed Name and Title

8-13-19 — Date

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

The above plan of correction is approved as of 9/9/19 (Date)

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

Plan of correction implementation status as of 9/9/19 (Date)

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

Plan of Correction: 41e

1. Immediate action taken: Residents rights reviewed with residents by Social Worker.
2. What specific change will be made: Resident rights addendum attached to Resident contract.
3. What implementation has been made to assure the violation does not occur again: Remain in electronic format in contract and reviewed at admission. Resident signature to verify receipt/review. Residents rights are reviewed at Resident Council meetings. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor receipt of a copy of residents rights and complaint procedures. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4. What training will be provided to staff: Admission personnel to add addendum to resident contract.
5. Supporting documents attached

MJ 9/9/19

42s - Privacy

Regulations

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 05/16/19, the home had cameras recording entrances, exits and interior public areas. However, residents have not been informed at admission that these areas are subject to video recording. Also, there are no signs posted stating images are being recorded.

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

Stephanie Messler
Signature

Stephanie Messler, PCHA
Printed Name and Title

8-13-19
Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction: 42s

1.Immediate action taken: Signs were posted at time of inspection; however, they have been updated to state 24-hour video recording.
2.What specific change will be made: Signs were updated to display "24-hour video recording"
3. What implementation has been made to assure the violation does not occur again: Signs to remain in place at entrances, exits and interior public areas. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for security camera videoing postings. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4.What training will be provided to staff: include check during environmental rounds.
5.Attach supporting documentation to verify compliance of any corrected violation: see attached

MJ 9/9/19

MEADOWOOD

127870

(i)

131f - Fire Extinguisher Inspection

Regulations

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the main kitchen has not been inspected by a fire safety expert since 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

Legal Entity Representative

Signature	Printed Name and Title	Date
Stephanie Messler	Stephanie Messler, PCHA	8-13-19

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction: 131f

1. Immediate correction taken: Call to Keystone Fire Protection Co. and they inspected the extinguisher in question.
2. What specific change will be made: Check list of extinguishers used for inspection
3. What implementation has been made to assure the violation does not occur again: Checklist reviewed after company inspection to assure all have been inspected. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for fire extinguisher inspection. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4. What training will be provided to staff: staff education provided.
5. Attach supporting documentation to verify compliance of any corrected violation: checklist, diagram, service ticket, QAPI

MJ 9/9/19

132h - Designated Meeting Place

Regulations

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 09/12/18 at 12:25 A.M., 2 residents did not evacuate to a fire-safe area within the 12 minute evacuation time frame.

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

Stephanie Messer — Signature

Stephanie Messer, PCMA — Printed Name and Title

8-13-19 — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction 132h

1. Immediate correction taken: Residents mentioned were provided education on fire drill participation.
2. What specific change will be made: Fire Drill procedure will be presented quarterly at Resident Council meetings. Presentations scheduled for August 14, November 13, January 8, and May 13 respectively.
3. What implementation has been made to assure the violation does not occur again: Close monitoring of fire drill reports and provide 1:1 education as needed. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for fire drill evacuation procedure. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4. What training will be provided to staff: Remind residents to attend Resident Council meetings; provide any handouts to Residents who did not attend.
5. Attach supporting documentation to verify compliance of any corrected violation: See fire drill response reports June, July, August. Addendum E: Laurel House rules within Laurel House contract.

MJ 9/9/19

183d - Prescription Current 1

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 05/17/19, Robitussin Cough-Chest Congestion DM 5 prescribed for resident #1, was in the home's Med cart; however, the medication was discontinued on 03/01/19.

Repeat Violation: 09/11/17

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

Stephanie Messer — Stephanie Messer, RHA — 8-13-19

Signature — Printed Name and Title — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction: 183d

1. Immediate correction taken: Medication removed from the assigned cart.
2. What specific change will be made: Monthly assigned cart audits to nursing/med tech staff plus 1 random monthly audit, as well as CPS pharmacy monthly audit.
3. What system has been implemented to make sure that the same violation will not occur again: Plan mentioned above, plus review of med cart audit binder before end of month. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for current prescriptions. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4. What training will be provided to staff: Reviewed at Team meeting the expectations of med cart audits and the safety behavior "STAR" (Stop, Think, Act, Review)
5. Attach supporting documentation to verify compliance of any corrected violation: see attachments

MJ 9/9/19

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #2 is prescribed Vitamin E (dl, acetate) 100 unit capsule one time daily. However, the home has been administering Sundown Naturals 180mg/400IU over the counter medication one time daily.

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

Stephanie Messler
Signature

Stephanie Messler, PCHA
Printed Name and Title

8-13-19
Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction: 187d

1. Immediate correction take: Order corrected.
2. What specific change will be made.: New EMR Point Click Care EMAR along with CPS pharmacy interface is anticipated to eliminate discrepancies.
3. What system has been implemented to make sure that the same violation will not occur again: Monthly cart audits by nursing/med tech staff plus 1 random monthly audit. CPS pharmacy monthly audit. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for following prescriber's orders. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.

4. What training will be provided to staff: Reviewed violation and educated in monthly Team meeting. Educated team about the safety behavior, "STAR" (Stop, Think, Act, Review) Ask clarifying questions to confirm orders.
5. Attach supporting documentation to verify compliance of any corrected violation: See attachments.

MJ 9/9/19

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

Documentation that the residents have been educated on the resident's right to refuse medication if the resident believes that there may be a medication error is not available.

Repeat Violation: 09/11/17

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

Stephanie Messer — Signature

Stephanie Messer, PCHA — Printed Name and Title

8-13-19 — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction: 191

1. Immediate correction taken: Residents Rights addendum have been added to resident contract May 2019. Residents rights reviewed with residents by social worker.
2. What specific change will be made: Residents rights will be reviewed at Resident Council meetings by social worker.
3. What system has been implemented to make sure that the same violation will not occur again.: Resident Rights is a part of monthly agenda at Resident Council meeting for review. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for resident's right to refuse included in signed contract. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4. What training will be provided to staff: Education provided to remind residents to attend Resident Council meetings and to continue to speak up for safety.
5. Attach supporting documentation to verify compliance of any corrected violation: See documents

MJ 9/9/19

227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3 participated in the development of his support plan on 12/19/18. However, the resident did not sign the support plan.

Resident #4 participated in the development of her support plan on 02/28/19. However, the resident did not sign the support plan.

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

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- ☐ Not Implemented

Plan of Correction: 227g

1. Immediate correction taken: Review of prior months' RASPs to determine any gaps with participation signatures.
2. What specific change will be made: Review of completed RASPs monthly for attendance/participation signatures.
3. What system has been implemented to make sure that the same violation will not occur again: At end of each month, RASPs will be reviewed by team member for completion. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for support plan signatures. Findings of the audits will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4. What training will be provided to staff: Review of violation at team meeting. Discussion of plan with team: All residents will be encouraged to sign their RASP. If they are unable to sign, they may make a mark to signify attendance. If the resident cannot sign or refuses to sign, it will be noted on RASP.
5. Attach supporting documentation to verify compliance of any corrected violation : see attachments

MJ 9/9/19

233d - Electronic/Magnetic System

Regulations

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The doors opening into the parking lot from the Azalea House patio are not locked with an electronic or magnetic locking system.

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.)

Within 5 days of completion of installation documentation will be submitted to M. Johnson at the Southeast Regional office at ra-pwarlsoutheast@pa.gov or faxed at 610-270-1147. MJ 9/9/19

Dll attached

Legal Entity Representative

Stephanie Messler — Stephanie Messler, PCHA — 8-13-19

Signature | Printed Name and Title | Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction: 233d

1. Immediate correction taken: Company contacted for pricing and stats
2. What specific change will be made: Installation of replacement gate and magnetic lock system
3. What system has been implemented to make sure that the same violation will not occur again: Installation of new gate scheduled for 08/09/2019. Mag lock is ordered and pending installation. A Quality Assurance/Performance Improvement plan will be developed and utilized to monitor for installation of magnetic lock (lock is ordered). Findings of the audit will be reported to the facility Quality Assurance Performance Improvement committee to determine need for additional actions and or monitoring.
4. What training will be provided to staff: Once gate and lock are installed, protocols will be reviewed for gate and magnetic lock.
5. Attach supporting documentation to verify compliance of any corrected violation: see attachment

MJ 9/9/19