



pennsylvania
DEPARTMENT OF HUMAN SERVICES

August 26, 2019

Ms. Terrie Gulliver
Assistant Executive Director
Masonic Village of the Grand Lodge of Pennsylvania
801 Ridge Pike
Lafayette Hill, Pennsylvania 19444

RE: Masonic Village of Lafayette Hill
License #: 138700

Dear Ms. Gulliver:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 12 & 13, 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 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, appearing to read "Kevin Hancock".

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: MASONIC VILLAGE OF LAFAYETTE HILL

License Number: 138700

Address: 801 RIDGE PIKE, LAFAYETTE HILL, PA 19444

County: MONTGOMERY

Region: SOUTHEAST

Administrator

Name: Donna Hartnett

Phone: 6108256100

Email: Dhartnett@MASONICVILLAGES.ORG

Legal Entity

Name: MASONIC VILLAGES OF THE GRAND LODGE OF PENNSYLVANIA

Address: 801 RIDGE PIKE, PA, 19444

Certificate(s) of Occupancy

Type: C-2 LP

Date: 04/10/1989

Issued By: L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 37

Waking Staff: 28

Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal

Inspection Dates and Department Representative

06/12/2019 - On-Site: Youn Hie Chung

06/13/2019 - On-Site: Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 51

Residents Served: 37

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: 37

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 0

Have Physical Disability: 0

123c - Evacuation Diagrams

Regulations

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 37 residents, However, there are no emergency evacuation diagrams posted on the second floor which comprises the Personal Care 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.)

Evacuation diagrams are now posted in each corridor of the Personal Care area. The signs were posted by our maintenance department as soon as we were alerted by the surveyor of the need. The evacuation diagrams were present prior to the surveyor leaving the building. The diagrams were posted immediately. The Personal Care Administrator will oversee this process to ensure the signs are available and visible at all times through a quarterly check of the signs. The Personal Care Administrator will report that the signs are present at our quarterly QAPI meeting.

Legal Entity Representative

T. Gulliver, NHA

Terrie Gulliver, NHA 7-24-2019

Signature

Printed Name and Title

Date

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

The above plan of correction is approved as of 8/6/19
(Date)

Plan of correction implementation status as of 8/6/19
(Date)

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

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

132f - Alternate Exit Routes

Regulations

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home used the same exit routes #1 and #4 during the fire drills held from 12/2018 to 04/2019.

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.)

We would like to dispute this violation. An analysis of drills conducted over a year (5/18 through 4/19) shows that routes were varied depending on the location of the simulated fire. Given the small size of the unit there are limitations on the number of locations to simulate a fire as well as limited exit route. In consulting with our fire safety expert, the Township of Whitemarsh, it has been determined that evacuating horizontally is far safer then evacuating vertically i.e. down a flight of stairs. Considering the number of our residents with ambulatory issues, it is the safest and best practice to evacuate horizontally instead of vertically both for training and actual emergencies. This is why routes 1 and 4 often appear. However over the course of a year, other exits are used.

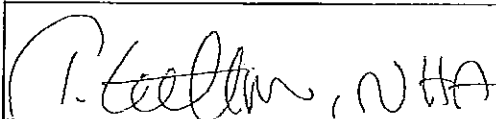
Plan of Correction: If this explanation is not acceptable- following is the plan of correction: Fire drills will be varied according to regulation 132f. This will be overseen and monitored by the Director of Environmental Services. The change will occur immediately. The Director of Environmental Services will work with Whitemarsh Fire Marshall to determine the best and safest variation of routes. A report of the route (utilizing the adult residential licensing- Pa Homes fire drill record form) will be kept in the Environmental Services office and monitored by the Director of Environmental Services to ensure that routes are varied.

Attached is listing of last year of routes.

The Administrator will review completed fire drills form monthly to ensure compliance with the cited reg

AAA

Legal Entity Representative



Terrie Gulliver NHA 7-24-2019

Signature

Printed Name and Title

Date

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

The above plan of correction is approved as of

8/6/19

(Date)

Plan of correction implementation status as of

8/6/19

(Date)

The above plan of correction was approved by

AAA

(Initials)

Fully Implemented

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

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

The medical evaluation for resident #1, admitted 11/27/2017, was completed on 06/13/2017.

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.)

Regulation 141a Plan of correction. When a new resident is admitted to the Personal Care Unit , a medical evaluation will be completed sixty days prior to the admission or thirty days after their admission.

When a resident comes to the community for their pre admission evaluation they will be informed that a medical evaluation must be completed by their physician sixty days prior to their admission or thirty days after their admission. Nursing will immediately schedule an appointment with the physician if not completed by day of admission.

The Personal Care Administrator will implement the change and the change will be implemented immediately. Nursing will ensure that evaluation is completed by checking day one of admission for the evaluation and if not completed scheduling an appointment with the physician. Audits will also be performed by the nursing staff which will be monitored by the Personal Care Administrator and Assistant Executive Director and reviewed at the quarterly QAPI meeting.

Staff training will be completed. Staff training form and audit form are attached.

AAA

The Administrator or a designee will create a checklist/tracking list that will prompt the need for a medical eval. to be completed as well as other regulatory requirements pertaining to a new admission. 8/6/19

Legal Entity Representative

	Terrie Gulliver, NHA	7-24-2019
---	----------------------	-----------

Signature

Printed Name and Title

Date

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

The above plan of correction is approved as of 8/6/19
(Date)

Plan of correction implementation status as of 8/6/19
(Date)

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

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

06/12/2019

4 of 7

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 06/13/2019 at 09:45 AM, the glucometer for resident #2 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.)

Regulation 185.a Plan of Correction. Every Glucometer will be checked daily for the correct date and time.

The Personal Care Administrator will implement the change and the change will be immediate. System changes will include staff training regarding the need to check the date and time daily on glucometers and an audit to ensure the continued compliance. Glucometer audits will occur daily and will be overseen by the Personal Care Administrator and the Assistant Executive Director. Audits will be reviewed at the quarterly QAPI meeting.

The Administrator will create a tracking/checklist to ensure that all residents glucometers are functioning properly and calibrated to the proper dates and time daily. The checklist will include any manufactures's instruction for the glucometer and when the battery for the device should be changed.

8/6/19

AAA

Legal Entity Representative

P. Gulliver, NHA

Terrie Gulliver, NHA

7-24-2019

Signature

Printed Name and Title

Date

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

The above plan of correction is approved as of

8/6/19

(Date)

Plan of correction implementation status as of

8/6/19

(Date)

The above plan of correction was approved by

AAA

(Initials)

Fully Implemented

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

06/12/2019

5 of 7

186b - Medication Used by Resident

Regulations

2600.

186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 03/30/2019 at 08:00 AM, resident #3 was administered Finasteride 5 mg, Carvedilol 6.25 mg, and Tamsulo. 0.4 mg prescribed for and belonging to resident #4.

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.)


Regulation 186b Plan of Correction. A Name Alert will be applied to both of the resident's EMARS that were named in the violation. This will alert the nursing staff to be aware of similar or same names when administering these medications.

The Personal Care Administrator will implement the change. The change will be implemented immediately. Nursing staff will be trained in Name Alerts. Staff will also be educated on medication administration, triple checking names with resident picture to ensure the resident is receiving their prescribed medication. The training will be reviewed at the quarterly QAPI meeting. The process will be overseen by the Personal Care Administrator and the Assistant Executive Director.

On receiving this POC and for the next 3 consecutive months period, the Administrator or a designee will provide oversight to staff with med. administration privileges during a particular med administration time daily. Such oversight, will ensure that staffs are following the proper medication administration protocols and that they are familiar with the use of the EMARS name alert system. The training and oversight provided to staff will be documented. 8/6/19

AAA

Legal Entity Representative

	Terrie Gulliver, NHA	7-19-2019
Signature	Printed Name and Title	Date

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

The above plan of correction is approved as of 8/6/19 Plan of correction implementation status as of 8/6/19
 (Date) (Date)

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

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

06/12/2019

6 <

187d Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #5 is prescribed Caltrate with Vitamin D 3 600 mg and Pramipexole Er 1.5 mg. However, these medications were not administered to the resident on 06/10/2019 because the medications were not available 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.)

Regulation 186b Plan of Correction. All medications will be checked by the nursing staff the day they are received from pharmacy to ensure all medications have been received. The Personal Care Administrator will oversee the change. The change will be implemented immediately. The nursing staff will be trained to audit the medication weekly and to check all medications sent by pharmacy. The Emar will be audited weekly by nursing staff to ensure that all medications are in the cart that have been prescribed for each resident. The audits will be reviewed at the quarterly QAPI meeting. The process will be overseen by the Personal Care Administrator and the Assistant Executive Director. On receiving this POC, the Administrator or a designee will audit MARS, med carts and prescription orders to ensure that all residents do have their prescribed meds readily available for use. In addition to the weekly med cart audit, the administrator will audit/review MARS/med cart when there is a change in a resident's prescribed medication and at the begining of each monthly med cycle. The Administrator will liase with pharmacy provider to procure residents meds timely. 8/6/19

AAA

Legal Entity Representative

Terrie Gulliver NHA Terrie Gulliver, NHA 7-24-2019

Signature

Printed Name and Title

Date

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

The above plan of correction is approved as of 8/6/19 (Date)

Plan of correction implementation status as of 8/6/19 (Date)

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

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