pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: dianed@abingtonmanor.com
MAILING DATE: November 7, 2019

Ms. Susan Sartoretto
Owner
Cedar Park Assisted Living, LLC
4161 Walter Road
Bethlehem, Pennsylvania 18020

RE: Abington Manor at Morgan Hill
215 Cedar Park Boulevard
Easton, Pennsylvania 18042
License #: 219620

Dear Ms. Sartoretto:

As a result of the Department's Bureau of Human Services Licensing inspection on July 11, 2019 of the above facility, the citations 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.

Sincerely,

M. Moskalczyk

Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: *ABINGTON MANOR AT MORGAN HILL* License Number: *21962*
Address: *215 CEDAR PARK BOULEVARD,, EASTON, PA 18042*
County: *NORTHAMPTON* Region: *NORTHEAST*

Administrator

Name: *Diane Dellacona* Phone: *6108290100* Email: *dianed@abingtonmanor.com*

Legal Entity

Name: *CEDAR PARK ASSISTED LIVING, LLC*
Address: *215 CEDAR PARK BOULEVARD, EASTON, PA, 18042*

Certificate(s) of Occupancy

Type: *I-2* Date: Issued By:

Staffing Hours

Resident Support Staff: Total Daily Staff: *72* Waking Staff: *54*

Inspection

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

Inspection Dates and Department Representative

07/11/2019 - On-Site: Ann O'Haire, Jason Harvey

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* Residents Served: *56*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *0*
Have Mobility Need: *16*
Are 60 Years of Age or Older: *53*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *1*

23a - Activities of Daily Living Assistance

Regulations

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

On 7/2/19 at approximately 5 AM resident #3 asked staff person "A" to open their bottle of water, staff person" A "responded "No" and proceeded to move the bottle of water away from resident #3. Resident #3 did not receive ADL's service from staff person "A".

Resident #4 requires assistance with toileting and transfers and her call bell log was reviewed. On 07/03/19 it was determined that Resident #4 waited 53 minutes for her call bell to be responded to and on 07-04-19 she waited 25 minutes for staff to respond to her request for assistance.

Resident #5's RASP dated 10/12/18 indicates the resident needs assistance getting in and out of bed and toileting. On 7/3/19 from 9:05 AM-9:12 AM resident #5 waited 7 minutes for assistance for toileting and from 5:37PM -5:49 PM resident waited 12 minutes for assistance for toileting.

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.)

It is always our intention as a facility to maintain compliance with DHS regulations. Regarding resident #3's inability to open a bottle of water and she did not recieve ADL's service from staff person A. This was reported as neglect to RAA and DHS about this staff person, whom I felt neglected to meet Resident #3's needs at the time and that's the way she reported it to me. STAFF person "A" was terminated shortly after this incident and since then we have been able to meet the needs of resident #3.

Resident #4's wait time for her call bell to be answered is completely unacceptable for our facility at any time for a resident to wait that long for a response. As a facility and as an E.D. and LRC we have been educating our staff on acceptable wait times and call bells have been answered in a more timely manner.

Resident #5's wait time was improved upon after this incident as well as #4's. Staff will continue to be educated on the importance of timeliness of answering to residents needs.

Immediately & Ongoing:

Legal Entity Representative The administrator shall monitor resident's ADL weekly for 3 months.

11/6/19 MM

Diane Dellacuna E.D. Diane Dellacuna, E.D. 10/18/19

Signature Printed Name and Title Date

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The above plan of correction is approved as of	11-6-19 (Date)	Plan of correction implementation status as of	11-6-19 (Date)
The above plan of correction was approved by	MM (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's fire drill log indicates the home is not alternating exit routes during monthly fire drills. The home's fire drill log indicates the home used the front exit and the fire safe stairwells during monthly fire drills on the following dates: 6/24/19, 5/20/19, 4/22/19, 3/22/19, 2/16/19, 2/16/19, 1/31/19, 12/31/18, 11/14/18, 10/4/18, 9/26/18, 8/23/18 and 7/22/19.

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.)

It is always our intention to be in compliance with DHS regulations. Our fire safety manager will be and has been alternating exit routes during our monthly fire drills and will continue to do so.

Immediately & Ongoing:
The administrator shall monitor ALL monthly fire drills and ensure that alternate exit routes are being used. Monitoring shall be monthly x's 6 months.

11/6/19 MM

Legal Entity Representative

Signature	Printed Name and Title	Date
Diane Dellacono, E. D.	Diane Dellacono, E. D.	10/18/19

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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

The support plan for resident # 3 dated 6/20/19 was not signed by the resident nor was there any documentation of the resident's inability or refusal to 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.)

It is always our facilities intention to be in compliance with DHS regulations. Resident #3's support plan dated 6/20/19 was not signed as an oversight by the Executive Director. It will be in our practice to have a check system between the DRC and Executive Director to make sure all support plans are signed by the resident before being placed on the charts.

Immediately & Ongoing:
The administrator shall AUDIT all resident's RASP for signatures, both current and future residents and admissions.
The AUDIT shall start within 5 days of receipt of this Plan of Correction and continue for 3 months thereafter to ensure ongoing compliance.

11/6/19 MM

Legal Entity Representative

Signature	Printed Name and Title	Date
Diane Dellocco, E. D.	Diane Dellocco, E. D.	10/18/19

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252 - Record Content

Regulations

2600.

252. Content of Resident Records - Each resident's record must include the following information:

3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident # 3 had a photograph dated 6/2017 in their record that is more than two years old.

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.)

It is always our facilities intention to be in compliance with CHS regulations. Resident #3 had a photograph dated 6/2017. All photographs have since been updated on all charts in the facility by the Administrative Assistant and will remain in compliance to update photos every two years.

Immediately & Ongoing:

The administrator shall AUDIT all resident's records for current, updated photographs.

The AUDIT shall start within 5 days of receipt of this Plan of Correction and continue for 3 months thereafter to ensure ongoing compliance.

11/6/19 MM

Legal Entity Representative

Signature	Printed Name and Title	Date
Diane Dellacava, E.D.	Diane Dellacava, E.D.	10/18/19

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