pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail dmcmillian@ch.kendal.org
Sent via e-mail nalba@ch.kendal.org
February 20, 2020

Ms. Dakia McMillian
Executive Director
Chandler Hall Health Services, Inc.
99 Barclay Street
Newtown, Pennsylvania 18940

RE: Chandler Hall Health Services, Inc.
Jordan-Phelps
License #: 129890

Dear Ms. McMillian:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 3, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Claire Mendez

Claire Mendez
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *CHANDLER HALL HEALTH SERVICES, INC. - JORDANS-PHELPS* **License Number:** *12989*
Address: *99 BARCLAY STREET,, NEWTOWN, PA 18940*
County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: *Nora Alba* **Phone:** *2158604000* **Email:** *NALBA@CH.KENDAL.ORG*

Legal Entity

Name: *CHANDLER HALL HEALTH SERVICES INC*
Address: *99 BARCLAY STREET, NEWTOWN, PA, 18940*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/29/1986* **Issued By:** *COPA L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *69* **Waking Staff:** *52*

Inspection

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

Inspection Dates and Department Representative

12/03/2019 - On-Site: Denise Gillespie, Sabrina Freeman

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served:** *44*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *44*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *25*
Have Physical Disability: *0*

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 3/9/19, Resident # 1 was offered Lasix and Resident # 1 refused because this is not a medication Resident # 1 is prescribed. The physician's order for Resident # 1 for Lasix is 8/9/18. The home did not report this incident to the department until 3/11/19.

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.)

Violation as noted above 16c:

What was done immediately:

The PC Administrator was informed on 3/10/19 that the above transcription error may have occurred. On 3/9/19 The resident #1 reported to the medication Care Partner that she does not take a dose of Lasix at 7pm once a month. The Medication Record showed the medication was to be given at 7pm once a month. On 3/10 The nurse looked for original physician order and it read to give a one time order. It was discovered that the nurse did not use the electronic medication record correctly causing it to carry over from one month to the next. The PC Administrator reported it on 3/11/19 within 24 hours of being informed of the error.

On going:

The PC Administrator will continue to report all incidents within 24 hours.

The home will review all incident reports at the monthly QAPI meeting to ensure that all incidents are being reported timely.

Legal Entity Representative

Nora Alba — Signature

Nora Alba PC Administrator — Printed Name and Title

1-7-2020 — Date

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

The above plan of correction is approved as of 2/14/2020 (Date)

Plan of correction implementation status as of 2/14/2020 (Date)

☑ Fully Implemented
☐ Not Implemented

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

188b - Medication Error Reporting

Regulations

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident # 1 is prescribed Lasix 40 mg one tablet once daily . However, Resident # 1's Lasix was discontinued on 8/9/18. Resident # 1 was administered the Lasix on 9/9/18, 10/9/18, 11/9/18, 12/9/18, 1/9/19, and 2/9/19. The Resident refused this medication on 3/9/19. The home reported the error to the department on 3/11/19.

Resident # 2 was scheduled to receive Sertraline at 5:00 P.M. on 7/28/19. The medication care partner administered Potassium 10 meq instead. Resident # 2 was not prescribed Potassium 10 meq. The home reported this error to the Department on 7/29/19.

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.)

See attachment #1 & #2

Legal Entity Representative

Nora Alba | Nora Alba pc Administrator | 1/7/2020

Signature | Printed Name and Title | Date

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Violation as noted above 188b:

Attachment #1

Resident #1:

What was done immediately:

The Physician and Resident were notified of the medication error.

The nurse was educated immediately on how to transcribe the order correctly in the electronic medication record.

What will be done:

On 12/16/19: The nurses were educated to have a second nurse check the transcription of orders to ensure the orders are transcribed as ordered by the physician. A red Line is to be written on the order with the signature of the nurse that did the second check.

On going:

All new nurses will be oriented that all new orders that are transcribed, are to be rechecked by a second nurse for accuracy and a red line written on the order with the signature of the nurse that did the second check.

Thora Alba PC Administrator Nova Alba PCA 1/7/2020

Attachment #2

Violation as noted above 188b:

Resident #2:

What was done immediately:

The resident was monitored and did not have a negative outcome

The Resident, POA and Physician was notified the medication error.

The Medication Care Partner was immediately educated on 7/29/19 by the Medication Train the Trainer, to always check the 5 rights prior to administering medications and if she finds it does not match she is to notify a nurse and not administer the medication.

If the Medication Care Partner has another error she will have additional medication administration observations conducted.

On-going:

On 1/20-1/25/2020 and Quarterly (April, July and October) for 2020:

A Mandatory Medication Administration Best Practices Class will be held by the Medication Train the Trainer with the Medication Care Partners.

Nora Alba PC Administrator Nora Alba PCA 1/7/2020

252 - Record Content

Regulations

2600.

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

Description of Violation

Resident 3's record does not include the reportable incident dated 6/3/19 .

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.)

Violation as noted above 252:

What was done immediately:

The incident report was added to resident #3 medical record.

All resident records were audited for 2019 incident reportables to confirm that there is a copy both in the reportable binder and there is a copy in the resident records that match.

What will be done on going:

The Personal Care Administrative Coordinator will audit the resident records quarterly to ensure all resident records have the incident reports in the resident record.

Legal Entity Representative

Nora Alba — Nora Alba PC Administrator 1/7/2020

Signature | Printed Name and Title | Date

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