pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail dshenk@telhai.org
Sent via e-mail cdallara@telhai.org
July 28, 2020

Mr. David Shenk
President and Chief Executive Officer
Tel Hai Retirement Community
P.O. Box 190
1200 Tel Hai Circle
Honey Brook, PA 19344

RE: Lakeview at Tel Hai Personal Care
P.O. Box 190
4200 Tel Hai Circle
Honey Brook, PA 19344
License #: 173640

Dear Mr. Shenk:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 19, 2019 and January 30 and 31, 2020 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: *LAKEVIEW AT TEL HAI PERSONAL CARE* License Number: *17364*

Address: *PO BOX 190,4200 TEL HAI CIRCLE,, HONEY BROOK, PA 19344*

County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: *Cynthia Dallara* Phone: *6102739333* Email: *Cdallara@TELHAI.ORG*

Legal Entity

Name: *TEL HAI RETIREMENT COMMUNITY*

Address: *PO BOX 190,1200 TEL HAI CIRCLE, HONEY BROOK, PA, 19344*

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: Total Daily Staff: *106* Waking Staff: *80*

Inspection

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

Reason: *Incident*

Inspection Dates and Department Representative

12/19/2019 - On-Site: Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* Residents Served: *82*

Secured Dementia Care Unit

In Home: *Yes* Area: *Ground floor* Capacity: *7* Residents Served: *6*

Hospice

Current Residents: *x*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *82*

Diagnosed with Mental Illness: *2*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *24*

Have Physical Disability: *3*

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On the evening of 10/21/2019 and morning of 10/22/2019, the home checked resident #1's blood glucose level with resident #2's glucometer and resident #2's with resident #1's glucometer.

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.)

1. Glucometer error was reviewed with the team members responsible, physicians, responsible parties and resident at the time of the incident.
2. All insulin and blood sugar supplies are kept in a locked box in the resident closet or in the nursing office of Adult Day Services. Pictures of residents have been added to the lockboxes as a second check that the team member has the correct resident.
3. Education related to the diabetes and glucometer policy will be reviewed with all Med Techs and nurses. This will be completed by January 31, 2020.
4. Health Services Coordinator will request physicians to review need and frequency of blood sugar checks for the effected residents by January 31, 2020.
5. Materials needed for insulin administration will be kept separately for each resident in a lock box. Lock box will resident in resident's room (resident #2) and nurses office (resident #1).
6. Glucometers are reviewed weekly by night shift LPN to assure no other incident of shared Glucometers occurs.
7. Audit of location of lock boxes will be completed for three weeks by either Health Services Coordinator or Administrator.
8. Three random observations of LPNs and insulin certified Med Techs will be completed using the "observation checklist" for the next three weeks.
9. Observations and audit results will be reviewed at the monthly Performance Improvement meetings.

Legal Entity Representative

Cynthia Dallara, RD, LDN, NHA — Signature
Cynthia Dallara — Printed Name and Title
Administrator, Personal Care — Printed Name and Title
1-21-20 — Date

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

The above plan of correction is approved as of 2/20/2020 (Date)

Plan of correction implementation status as of 2/20/2020 (Date)

☑ Implemented
☐ Not Implemented

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

182c - Medication Administration

Regulations

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
1. Identify the correct resident.
3. Remove the medication from the original container.

Description of Violation

On 11/26/2019 at 04:45 PM, resident #3 was administered Metformin 750 mg and Atorvastatin 40 mg, which belonged to resident #4. On 10/18/2019 at 06:15 PM, resident #5 was administered Xeralto 15 mg, which belonged to resident #6. The med-techs failed to identify the correct residents.

On 08/04/2019 at 08:04 PM, resident #7 was administered a Tramadol instead of her scheduled Lorazepam. The Tramadol belonged to another resident. The med-tech failed to read the label.

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.)

1. The team members were counseled regarding the medication errors. Residents, physicians and responsible parties were all notified of the error at the time it was identified.
2. Education related to medication errors for Med Techs and LPNs will be completed by the Health Services Coordinator by January 31, 2020.
3. Health Services Coordinator or designee will complete random Medication Administration Audits three times per week x three weeks.
4. Moving forward, any LPN or Med Tech having a med error will be required to be observed by an LPN or trained med administration observer before working on the cart independently. At least 3 medication observations will be completed. Depending on the severity of the medication error, the med tech may be required to be retrained on a particular med cart.
5. Med errors, education provided and results of audits will be reviewed at the Monthly PI meeting.

Legal Entity Representative

Cynthia Dallara RD, LDN, NHA
Signature

Administrator,
Cynthia Dallara Personal Care 1-21-2
Printed Name and Title Date

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Plan of correction implementation status as of 2/20/2020 (Date)

☑ Implemented
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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 11/26/2019 at 04:45 PM, resident #3 was administered Metformin 750 mg and Atorvastatin 40 mg, prescribed for and belonging to resident #4. On 10/18/2019 at 06:15 PM, resident #5 was administered Xeralto 15 mg, prescribed for and belonging to resident #6. On 08/04/2019 at 08:04 PM, resident #7 was administered a Tramadol prescribed for and belonging to another 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.)

1. The team members were counseled regarding the medication errors. Residents, physicians and responsible parties were all notified of the error at the time it was identified.
2. Education related to medication errors for Med Techs and LPNs will be completed by the Health Services Coordinator by January 31, 2020.
3. Health Services Coordinator or designee will complete random Medication Administration Audits three times per week x three weeks.
4. Moving forward, any LPN or Med Tech having a med error will be required to be observed by an LPN or trained med administration observer before working on the cart independently. At least 3 medication observations will be completed. Depending on the severity of the medication error, the med tech may be required to be retrained on a particular med cart.
5. Med errors, education provided and results of audits will be reviewed at the Monthly PI meeting.

Legal Entity Representative

Cynthia Dallara, RD, LDN, NHA — Signature

Cynthia Dallara Administrator, Personal Care — Printed Name and Title

1-21-20 — Date

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☑ Implemented
☐ Not Implemented

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

On 11/26/2019 at 04:45 PM, resident #3 was administered Metformin 750 mg and Atorvastatin 40 mg when she had no orders for these meds. 10/18/2019 at 06:15 PM, resident #5 was administered Xeralto 15 mg instead of her prescribed Warfarin. On 08/04/2019 at 08:06 PM, resident #7 was administered Tramadol instead of her prescribed Lorazepam.

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.)

1. The team members were counseled regarding the medication errors. Residents, physicians and responsible parties were all notified of the error at the time it was identified.
2. Education related to medication errors for Med Techs and LPNs will be completed by the Health Services Coordinator by January 31, 2020.
3. Health Services Coordinator or designee will complete random Medication Administration Audits three times per week x three weeks.
4. Moving forward, any LPN or Med Tech having a med error will be required to be observed by an LPN or trained med administration observer before working on the cart independently. At least 3 medication observations will be completed. Depending on the severity of the medication error, the med tech may be required to be retrained on a particular med cart.
5. Med errors, education provided and results of audits will be reviewed at the Monthly PI meeting.

Legal Entity Representative

Cynthia Dallara, RD, LDN, NHA
Signature

Administrator,
Cynthia Dallara Personal Care 1-21-20
Printed Name and Title Date

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234d - Support Plan Revision

Regulations

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #7 was completed on 11/11/2019. She did not have any aggression or agitation problems; however, the resident's overall condition has declined and she started to display aggression by hitting staff and other residents. The home failed to address this change in her behavior in her 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.)

234d

1. Resident is no longer residing in facility
2. Moving forward any resident who displays a change in behavior will be reviewed in the twice weekly stand up meeting and support plan will be updated at that time.
3. Health Services Coordinator and LPNs will be responsible for updating the support plan.
4. Audit of 10 resident support plans will be completed to make sure current behavioral health needs are addressed on the support plan by January 31, 2020. Audit will be completed by Health Service Coordinator or designee.
5. Results of the audit will be reviewed at the monthly PI meeting

Legal Entity Representative

Administrator

Cynthia Dallara RD, LDN, NHA — Signature

Cynthia Dallara Personal Care — Printed Name and Title

1-21-2020 — Date

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☑ Implemented
☐ Not Implemented

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Violation Report

Facility Information

Name: *LAKEVIEW AT TEL HAI PERSONAL CARE* License Number: *17364*
Address: *PO BOX 190,4200 TEL HAI CIRCLE,, HONEY BROOK, PA 19344*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: *Cynthia Dallara* Phone: *6102739333* Email: *DSHENK@TELHAI.ORG*

Legal Entity

Name: *TEL HAI RETIREMENT COMMUNITY*
Address: *PO BOX 190,1200 TEL HAI CIRCLE, HONEY BROOK, PA, 19344*

Certificate(s) of Occupancy

Type: *I-2* Date: *05/27/1988* Issued By: *Honey Brook Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *108* Waking Staff: *81*

Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*
Reason: *Renewal , POC Verification*

Inspection Dates and Department Representative

01/30/2020 - On-Site: Susan Smith, Sandi Wooters

01/31/2020 - On-Site: Susan Smith, Sandi Wooters

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* Residents Served: *83*

Secured Dementia Care Unit

In Home: *Yes* Area: *Mapleview* Capacity: *0* Residents Served: *7*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *83*
Diagnosed with Mental Illness: *2*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *25*
Have Physical Disability: *3*

LAKEVIEW AT TEL HAI PERSONAL CARE 17364

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 persons A and B do not have documentation of having participated in or completed the annual required Personal Care Homes Resident Rights training for the 2019 training year.

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.)

The Personal Care Home Resident Rights form will be reviewed with team member A and team member B by March 6, 2020. They have both completed the Resident Rights Essentials In-service in 2019.

Education coordinator added the specific Personal Care Home Resident Rights for review by all direct care staff and ancillary staff- due to be reviewed in this education year by June 30 of 2020. Education plan was updated on 2/26/2020. (See attached plan). Resident Rights Essentials is also included on the in-service plan.

An audit of completion of resident rights training will be completed by July 31, 2020 by Administrator and/or designee. 25 random team members will be checked including both ancillary and Personal Care team members

Results of the audit will be reviewed at the Performance Improvement meeting in August 2020.

Legal Entity Representative

Cynthia Dallara RD, LDN, NHA — Signature

Cynthia Dallara Administrator, Personal Care — Printed Name and Title

2-28-20 — Date

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

Plan of correction implementation status as of 3/6/2020 (Date)

☑ Implemented
☐ Not Implemented

85d - Trash Receptacles

Regulations

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/31/20 at 8:35am there was a trashcan without a lid in the wash section of the main kitchen, as well as a trashcan without a lid in the cooking areas of the main kitchen.

At 9:15am on 1/31/20, there was an uncovered trash can located in the ancillary kitchen dishwashing area.

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.)

Trashcans in the kitchen will be covered when not in use.

Culinary Services Team Members were in-serviced regarding the use of trash can lids. In-service was completed on 1/31/2020 by Culinary Services Manager. (See attached in-service record)

Culinary Services Manager and/or designee will audit the use of trash cans to ensure lids are on receptacles twice a day for six weeks to ensure trash cans are covered. See Audit tool #1.

Audits will be reviewed at the Performance Improvement Meeting.

Legal Entity Representative

Cynthia Dallara RD, CDN, NHA
Signature

Cynthia Dallara
Administrator, Personal Care
Printed Name and Title

2-28-20
Date

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☑ Implemented
☐ Not Implemented

95 - Furniture and Equipment

Regulations

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The covering of the steam filter unit that is located near the cook stove of the ancillary kitchen was corroded with white calcium buildup. Also, there was excessive dust and dirt on top of the fire suppression system both in the main kitchen, and in the ancillary kitchen.

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.)

Steam Filter and Fire Suppression Systems were cleaned on 2/1/2020.

Both steam filter unit and fire suppression systems will be added to Culinary Services Cleaning list.

Culinary Services Manager and/or designee will audit the cleaning list monthly for six weeks to ensure the equipment is cleaned regularly. (See attached cleaning checklist.)

Results of the audit will be reviewed at Performance Improvement Meeting.

Legal Entity Representative

Cynthia Dallara

Cynthia Dallara RD, LDN, NHA — Signature

Administrator, Personal Care — Printed Name and Title

2-28-20 — Date

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☑ Implemented
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101i - Access to Bedroom

Regulations

2600.
101.i. A resident shall have access to his bedroom at all times.

Description of Violation

On 1/31/20, on the Secured Dementia Care Unit, all resident bedroom doors were found to be locked while the residents were in the activity room for program. Doors are unlocked if the resident makes a request to staff to go into their room.

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.)

Resident rooms were immediately unlocked.

Six of the 7 residents residing on the secured dementia unit have keys to their bedroom doors.

Staff education regarding keeping doors unlocked will be completed by the Adult Day Services Director by 3/6/2020.

An audit of the resident room's remaining unlocked will be completed three times per week, for four weeks by adult day services team member (see attached audit form)

Results of the audit will be reviewed at Performance Improvement Meeting.

Legal Entity Representative

Cynthia Dallara RD, LDN, NHA — Signature

Cynthia Dallara
Administrator, Personal Care — Printed Name and Title

2-28-20 — Date

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☑ Implemented
☐ Not Implemented

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

There was not a lamp or light source at the bedside of Resident #1 in room 106. Resident #1 sleeps in a recliner, per doctor's orders.

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.)

Resident was immediately provided a lamp for his room by the adult day services director.

An audit will be completed – 5 resident rooms will be checked for a lamp each week for the next 4 weeks. Audit to be completed by Administrator and/or designee. (see attached audit form)

Results of the audit will be reviewed at Performance Improvement Meeting.

Legal Entity Representative

Cynthia Dallara RD, LDN, NHA — Signature

Cynthia Dallara
Administrator, Personal Care — Printed Name and Title

2-28-2020 — Date

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103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 1/31/2020, there was an unattended cup of orange juice and open box of Cheerios located in the dry storage room in the main kitchen.

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.)

Open containers have been discarded. Staff are not permitted to eat in the Culinary areas.

Culinary Services Team Members have been in-serviced on the appropriate areas for personal drinking and eating. In-service was completed on 1/31/2020 by Culinary Services Manager. (See attached sign in sheets).

A trash receptacle has been placed in the dry storage area for items that need to be discarded durig the receiving an storage processes. (See attached picture).

Culinary Services Manager will audit kitchen and storage areas to ensure there is appropriate use of personal drinks and food two times a day for six weeks. (See audit tool #3)

Results of the audit will be reviewed at the monthly Performance Improvement Meeting.

Legal Entity Representative

Cynthia Dallara RD, LDN, NHA — Signature

Cynthia Dallara, Administrator, Personal Care — Printed Name and Title

2-28-20 — Date

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☑ Implemented
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LAKEVIEW AT TEL HAI PERSONAL CARE 17364

190c - Record of Training

Regulations

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The annual practicum certificates for Staff Persons C, D, & E are incomplete. They do not include all of the Med pass observation and MAR review results, or ultimately the results of the annual practicum re-certifications.

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.)

The annual practicum for staff persons C, D and E have been corrected and updated with med pass observations and MAR review results.

For future med pass observations and MAR reviews: all reviews will be noted on the Annual Practicum Recertification Form as they are completed and both bi-yearly audits will be documented on the same review/observation form.

The reviews and forms will be completed by a med-tech trainer and /or practicum observer. They then will be reviewed by the service facilitator and filed.

All documentation for med pass observations and MAR review completed from February through April will be reviewed at the monthly Performance Improvement Meeting.

Legal Entity Representative

Cynthia Dallara RD, LPN, NHA — Signature

Cynthia Dallara, Administrator, Personal Care — Printed Name and Title

2-28-2020 — Date

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LAKEVIEW AT TEL HAI PERSONAL CARE 17364

233c - Key-Locking Devices

Regulations

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU).

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.)

Signs were posted at the entrance to the secured area immediately (see attached pictures)

Education will be provided for team members regarding this regulation to be completed by 3/6/2020.

An audit to ensure that the signs remain posted at the entrance and exit to the secured unit will be completed three times a week for the next four weeks. Administrator and/or designee will be responsible for completing the audit. (see attached audit form)

Results of the audit will be reviewed at the Performance Improvement Meeting.

Legal Entity Representative

Cynthia Dallara RD, LDN, NHA — Signature

Cynthia Dallara
Administrator, Personal Care — Printed Name and Title

2-28-2020 — Date

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☐ Not Implemented