Sent via e-mail to: kareng@moravian.com
MAILING DATE: February 24, 2020

Ms. Susan C. Drabic
President and Chief Executive Officer
Morningstar Senior Living Inc.
175 West North Street
Nazareth, Pennsylvania 18064

RE: Moravian Hall Square
Personal Care Residences
License: 226280

Dear Ms. Drabic:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 15, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

M. Moskalczyk

Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *MORAVIAN HALL SQUARE PERSONAL CARE RESIDENCES* License Number: *22628*
Address: *175 WEST NORTH STREET,, NAZARETH, PA 18064*
County: *NORTHAMPTON* Region: *NORTHEAST*

Administrator

Name: *Karen Geiger* Phone: *6107461000* Email: *kareng@moravian.com*

Legal Entity

Name: *MORNINGSTAR SENIOR LIVING INC*
Address: *175 WEST NORTH STREET, NAZARETH, PA, 18064*

Certificate(s) of Occupancy

Type: *I-2* Date: *05/25/2004* Issued By: *Nazareth*
Type: *C-2 LP* Date: *02/23/2004* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *102* Waking Staff: *77*

Inspection

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

Inspection Dates and Department Representative

01/15/2020 - On-Site: Amy Deluca, Jason Harvey

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* Residents Served: *75*

Secured Dementia Care Unit

In Home: *Yes* Area: *na* Capacity: *25* Residents Served: *21*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *75*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *27*
Have Physical Disability: *2*

19 - Review Waiver

Regulations

2600.

19. Waivers

a. A home may submit a written request for a waiver of a specific requirement contained in this chapter. The waiver request must be on a form prescribed by the Department. The Secretary, or the Secretary's appointee, may grant a waiver of a specific requirement of this chapter if the following conditions are met:

1. There is no jeopardy to the residents.
2. There is an alternative for providing an equivalent level of health, safety and well-being protection of the residents.
3. Residents will benefit from the waiver of the requirement.

b. The scope, definitions, applicability or residents' rights under this chapter may not be waived.

c. At least 30 days prior to the submission of the completed written waiver request to the Department, the home shall provide a copy of the completed written waiver request to the affected resident and designated person to provide the opportunity to submit comments to the Department. The home shall provide the affected resident and designated person with the name, address and telephone number of the Department staff person to submit comments.

d. The home shall discuss the waiver request with the affected resident and designated person upon the request of the resident or designated person.

e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

f. The Department will review waivers annually to determine compliance with the conditions required by the waiver. The Department may revoke the waiver if the conditions required by the waiver are not met.

g. A waiver granted prior to October 24, 2005, is no longer in effect as of October 24, 2006.

Description of Violation

The home uses web-based program Point Click Care for creating the home's DMEs and Resident Assessment Support Plans. The home does not have a waiver from the Department to use this program.

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.)

A waiver request for the use of Point Click Care as a tool to develop and implement the home's DME and Support Plan will be submitted immediately. (See exhibit #1)

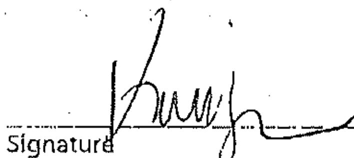
To ensure compliance future web based programs will not be implemented without waiver approval.

PCH Administrator will be responsible to submit waiver request.

Date of compliance 3/1/2020

Waiver approved - 2/19/2020
2-20-2020 - MM

Legal Entity Representative



Signature — Karen Geiger Personal Care Administrator 2/13/20
Printed Name and Title — Date

19 - Review Waiver *(continued)*

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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 MM (Initials)

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:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff person A was trained in fire safety for 2018 by staff person B on 10/11/2019. Staff person B was not trained by a fire safety expert to conduct fire safety training until 11/13/2019.

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.)

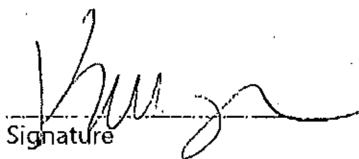
Staff person A is scheduled to participate in fire safety training with a fire safety training expert on 2/12/2020. (See exhibit #2)

To ensure compliance all direct care workers will receive fire safety training by a fire safety expert as required. An excel spread sheet program was created to to document and track attendance and ensure ongoing compliance.

PCH Administrator will review attendance quarterly and ensure that all direct care workers receive fire safety training by a fire safety expert.

Date of compliance 3/1/20

Legal Entity Representative



Signature

Karen Geiger Personal Care Administrator 2/13/20

Printed Name and Title Date

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81b - Resident Personal Equipment

Regulations

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident bedrooms 2011 and 2033 had enabler bars attached to the beds that were not covered, presenting an entrapment risk.

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.)

Upon discovery on 1/15/2020 the enablers were immediately covered.

To ensure compliance the nurse or designee will make routine daily rounds to check enablers and ensure that cover stays intact and re-apply when removed by resident.

Staff will be educated by 3/15/2020.(See exhibit #3)

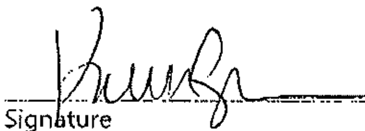
Residents/family to receive education at the March Resident Council regarding the importance of maintaining the cover on the enabler device for safety and to reduce entrapment risk.

PCH Administrator will research enabler devices for a style that does not present potential for entrapment when cover is removed.

PCH Administrator will complete random audits to monitor for compliance and report finding and corrective action at Quality Assurance Performance Improvement team.

Date of compliance 3/30/20

Legal Entity Representative



Signature | Karen Geiger PCH Administrator (Printed Name and Title) | 2/13/20 (Date)

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91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The telephone numbers required by this regulation were not posted by the phones located in room #'s 6, 11, 2022 and 2028.

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.)

Upon discovery on 1/15/2020 the phone numbers required by regulation were immediately attached and posted to room 6,11, 22, and 28.

To ensure future compliance the new Move-in Checklist will be revised to include placement of the phone numbers on or near the telephone. (See exhibit #4)

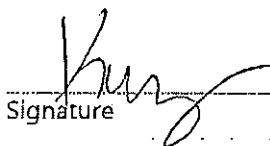
Staff education to be completed by 3/15/2020.(See exhibit #3)

Resident education regarding the importance of keeping the emergency numbers in view will be completed at March Resident Council.

PCH Administrator to conduct random audits to monitor for compliance and report findings and corrective action at Quality Assurance Performance improvement team.

Date of compliance 3/15/20

Legal Entity Representative



Signature | Karen Geiger PCH Administrator 2/13/20
Printed Name and Title | Date

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124 - Notice to Fire Department

Regulations

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home's notification to the local fire department did not include the total capacity of 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.)

Upon discovery on 1/15/2020 the 124 letter was revised to include licensed capacity.

PCH Administrator mailed on 2/5/2020 the letter through USPS with a Certificate of Mailing. (See exhibit #5)

To ensure compliance PCH Administrator will maintain the 124 letter in permanent file.

Date of compliance 3/1/20

Legal Entity Representative

Signature

Karen Geiger PCH Administrator 2/13/20

Printed Name and Title Date

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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

On 9/7/19 resident #1 did not evacuate during the fire drill while actively dying on hospice.

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.)

Upon review all residents including those on hospice will be evacuated during a fire drill. Hospice residents who have a physician order and documentation from the family not to participate are the only exception.

To ensure compliance the evacuation procedure will be reviewed and will include the hospice resident exception when applicable.

Staff education to be completed by 3/15/2020.(See exhibit #3)

The fire safety training agenda has been revised to include robust discussion of evacuation of hospice residents and the exception. (See exhibit #6)

Residents/family to be educated during the March Resident Council meeting.

PCH Administrator or designee to review monthly X3, then randomly the fire drill log for compliance. Findings and corrective action will be reported at Quality Assurance Performance Improvement.

Date of compliance 3/30/20

Legal Entity Representative

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133.1 - Exit Signs

Regulations

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

The exit door leading to the courtyard near the Gardenview room in the secure dementia unit was locked with a bolt and not marked "Not an exit".

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.)

Upon discovery on 1/15/2020 a sign that reads "This is Not an Exit" was immediately placed on the door leading to the courtyard. (See exhibit #7)

PCH Administrator or designee will conduct random audits to ensure that the sign remains present. Findings and any corrective action will be reported to Quality Assurance Performance Improvement.

Date of compliance 3/1/20

Legal Entity Representative

Signature

Karen Geiger PCH Administrator 2/13/20

Printed Name and Title — Date

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141a 1-10 Medical Evaluation Information

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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The medical evaluation for resident #2 dated 9/8/19 did not indicate the resident's height.

Plan of Correction (POC)

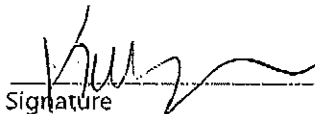
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Upon discovery on 1/15/2020 the medical evaluation for resident #2 was updated to include the resident's height. (See exhibit #8)

To ensure compliance PCH Administrator or designee to audit a random sample monthly for 3 months then quarterly thereafter. Findings and any corrective action will be reported at Quality Assurance Performance Improvement.

Date of compliance 3/1/20

Legal Entity Representative



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187a - Medication Record

Regulations

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
8. Frequency of administration.

Description of Violation

Resident #3 has a straight order for Albuterol to be inhaled orally 2 times per day for pneumonia. The medication label did not indicate the straight order for this medication. The label indicated the medication was to be inhaled one time every six hours as needed.

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.)

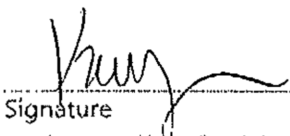
Upon discovery on 1/15/2020 the physician and pharmacy were immediately notified to correct the label.

To ensure compliance the nurse or med tech receiving the pharmacy delivery or any order changes from the physician are to check that the medication supply matches physician order and MAR and send back to the pharmacy for verification and relabeling when incorrect.

PCH Administrator or designee to perform random medication and MAR audits to monitor for compliance and report any findings and any corrective action to Quality Assurance Performance Improvement.

Date of compliance 3/1/20

Legal Entity Representative



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Printed Name and Title — Date

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231c - Preadmission Screening

Regulations

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the home's secure dementia unit on 11/13/19. The home did not complete a written cognitive preadmission screening for this 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.)

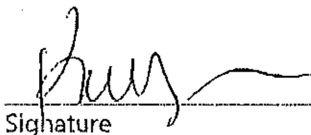
Upon discovery on 1/15/2020 resident #4 preadmission screen was corrected with the assessor's signature.(See exhibit #9)

To ensure compliance the preadmission screening for secure dementia unit will be reviewed by the nurse or designee prior to the move-in date.

PCH Administrator or designee will complete quarterly audit of preadmission screening of newly admitted residents to secure dementia area. Findings and any corrective action will be reported to Quality Assurance Performance Improvement.

Date of compliance 3/1/20

Legal Entity Representative



Signature | Karen Geiger PCH Administrator (Printed Name and Title) | 2/13/20 (Date)

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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 exit located next to room 4 in the secure dementia care unit did not open with the correct security code which was posted next to the door. The code had not been updated to the current month and year as the other doors in the unit had been updated.

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.)

Upon discovery on 1/15/2020 maintenance was contacted immediately and the door code was updated.

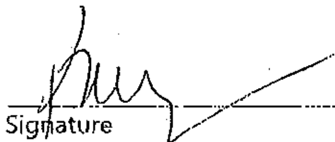
To ensure compliance Director of Maintenance or designee will make rounds to check door code at the beginning of each month.

Staff education to be completed by 3/15/2020. (See exhibit #3)

PCH Administrator will conduct random audit to check that door code has been updated.

Date of compliance 3/15/20

Legal Entity Representative



Signature

Karen Geiger PCH Administrator 2/[illegible]

Printed Name and Title Date

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