pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail jharper@arborcompany.com
Sent via e-mail mbasham@arborcompany.com
August 3, 2020

Mr. Judd Harper
President of the Management Company
SHP V Willistown, LLC
3715 Northside Parkway NW 300-110
Atlanta, Georgia 30327

RE: Arbor Terrace Willistown
1713 West Chester Pike
West Chester, Pennsylvania 19382
License #: 142450

Dear Mr. Harper:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 24 and 26, 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: *ARBOR TERRACE WILLISTOWN* **License Number:** *14245*
Address: *1713 WEST CHESTER PIKE, WEST CHESTER, PA 19382*
County: *CHESTER* **Region:** *SOUTHEAST*

Administrator

Name: *Marianne Basham* **Phone:** *6107251713* **Email:** *marianne.basham@ARBORCOMPANY.COM*

Legal Entity

Name: *SHP V WILLISTOWN LLC*
Address: *3715 NORTHSIDE PKWAY NW 300-110, ATLANTA, GA, 30327*

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *136* **Waking Staff:** *102*

Inspection

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

Inspection Dates and Department Representative

03/24/2020 - Off-Site: Youn Hie Chung

03/26/2020 - Off-Site: Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served:** *92*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *evergreen* **Capacity:** *35* **Residents Served:** *32*

Hospice

Current Residents: *xx*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *0*
Have Mobility Need: *44*
Are 60 Years of Age or Older: *90*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *1*

Marianne Basham
Executive Director

Marianne Basham

#142450

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

Resident #1 was prescribed Loteprednol Sus 0.5% 4 times a day starting December 16, 2019. However, resident #1 was given this eye drop 5 times a day from 12/17/2019 till 01/05/2020 except for a few days including 12/28/2019, 12/29/2019, 01/03/2020, and 01/04/2020. Staff members failed to check the frequency of this eye drop before administering it.

Resident #2 is prescribed Clonzepam 0.5 mg half tab 3 times a day as needed for anxiety. On 02/20/2020 at 06:53 PM, Resident #2 was given Alprazolam 0.25 mg instead of the prescribed Clonazepam. Staff A, who administered this medication, failed to remove the right medication for the 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.)

On 01/13/20 the community self reported a med error to DHS for Resident #1. The error was discovered during an audit and review of this Resident's Physician Orders by our Regional RN Clinical Specialist, while she was visiting our community. She noted that Resident #1 was prescribed eye drops and was to have 1 drop instilled in his left eye 4 times per day; however, he was receiving the 1 drop 5 times per day. She then noted that the order had been transcribed into the pharmacy system incorrectly, and she contacted the pharmacy. Our Clinical Specialist followed up with our Wellness Nurse, who then called the Physician to have the order for the incorrect dose discontinued, and got a new order for the right dose. To prevent this violation from happening again, our Specialist made arrangements to meet with our LPN/Shift Supervisors on 01/16/20 to facilitate an in-service to review the proper procedures, and best practices related to approving orders. They also discussed the expectations regarding interactions with the pharmacy. Our Specialist also facilitated a follow-up in-service for LPN/Shift Supervisors and Med Techs on 01/29/20 to cover Medication Safety, Recording, and Incident Reporting. (See Attachments #1 and #2)
On 2/21/20 the community self reported a med error to DHS for Resident #2, as Staff Member A administered the wrong PRN medication to Resident #2. Staff A was counseled, and then educated about the safety features that are part of the QuickMAR system.To prevent this violation from happening again, Med Tech staff will utilize the scanning feature as this is an added safety alert. The Resident Care Director and the Memory Care Director are responsible to check the QuickMAR Dashboard daily to review and validate that best practices around medication management are being followed. (See Attachment #3)

Legal Entity Representative

Marianne Basham — Signature

Marianne Basham Exec Dir — Printed Name and Title

7/28/20 — Date

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The above plan of correction is approved as of 8/3/2020 (Date)

Plan of correction implementation status as of 8/3/2020 (Date)

☑ Implemented
☐ Not Implemented

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

185a - Implement Storage Procedures

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

The home's medication administration policy states that if differences are found between the medication label and electronic medication administration record, staff should report them to the supervisor. Resident #1 was prescribed Loteprednol Sus 0.5% 4 times a day but the eMAR scheduled this eye drop 5 times a day and staff B noticed this discrepancy on 12/28/2019 but she did not report it to the supervisor.

The home's medication administration policy also states that medications should be scanned on the computer before administration to ensure the right medication for the right resident. Resident #2 is prescribed Clonazepam 0.5 mg half tab. On 02/20/2020 at 06:53 PM, the resident was given Aprazolam 0.25 mg instead of the prescribed Clonazepam. It is clear that staff A failed to scan the medication before administration.

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.)

On 01/13/20 the community self reported a med error to DHS for Resident #1. The error was discovered during an audit and review of this Resident's Physician Orders by our Regional RN Clinical Specialist, while she was visiting our community. She noted that Resident #1 was prescribed eye drops and was to have 1 drop instilled in his left eye 4 times per day; however, he was receiving the 1 drop 5 times per day. It was noted that Staff B did not follow our policy because she did not report the discrepancy she observed to her supervisor. To prevent this violation from happening again, our Specialist made arrangements to facilitate an in-service for LPN/Shift Supervisors and Med Techs on 01/29/20 to cover Medication Safety, Recording, and Incident Reporting. (See Attachments #2) The RCD checks the QuickMAR Dashboard daily. The RCD continues to review our Medication Management Policy with LPNs and Med Techs.(See Attachment #4 pages 1 to 5)
On 2/21/20 the community self reported a med error to DHS for Resident #2, as Staff Member A administered the wrong PRN medication to Resident #2. Staff A was counseled, and then educated about the safety features that are part of the QuickMAR system.To prevent this violation from happening again, Med Tech staff will utilize the scanning feature when signing out medication, as this is an added safety alert. The Resident Care Director and the Memory Care Director are responsible to check the QuickMAR Dashboard daily to review and validate that best practices around medication management are being followed. (See Attachment #3)

Legal Entity Representative

Signature Marianne Basham — Marianne Basham Executive Director — 7/28/20
Printed Name and Title — Date

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185b - Medication Procedures

Regulations

2600.
185.b. At a minimum, the procedures must include:
2. A process to investigate and account for missing medications and medication errors.

Description of Violation

Resident #3 is prescribed Alprazolam 0.25 mg 3 times a day. On 03/08/2020, the resident refused all her morning meds including Alprazolam 0.25 mg, which had already been signed out by staff C. The home says that this controlled med must have been disposed/wasted by 2 staff but there is no documentation to support this claim.

Plan of Correction (POC)

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On 03/08/2020 Resident #3 refused all of her morning medications. Although Staff C had documented the refusal of the medications, she had already signed out the 0.25mg dose of Alprazolam. When the resident refused the medications, staff person C should have notified the LPN Shift Supervisor or the shift lead regarding the need for disposal of the controlled medication, and documented it per the home's policy. She did not follow the policy.To prevent a reoccurrence of this violation, the Resident Care Director has reviewed the medication policies and procedures with staff. All staff handling medications have been reminded/instructed that any disposal/waste of a controlled medication needs to be done with two licensed/certified staff, and record of that disposal needs to be documented on the accompanied narcotic/controlled medication sheet. The home does have a policy regarding investigation of Medication Diversion, and controlled substances are monitored closely during each shift. Any disrepancy will be reported immediately and investigated thoroughly. The RDC, MCD, and Wellness Nurse are responsible to monitor the QuickMAR throughout their shifts to identify any missed medications, exceptions, etc.
(See attachment #6)

Legal Entity Representative

Marianne Basham Executive Dir 7/28/20

Signature | Printed Name and Title | Date

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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 02/20/2020 at 06:53 PM, resident #2 was administered Aprazolam 0.25 mg prescribed for and belonging to resident #3.

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.)

On 2/21/20 the community self reported a med error to DHS for Resident #2, as Staff Member A administered the wrong PRN medication to Resident #2, but instead gave medication that belonged to Resident #3. Staff A was counseled, and then educated about the safety features that are part of the QuickMAR system.To prevent this violation from happening again, Med Tech staff will utilize the scanning feature as this is an added safety alert. The Resident Care Director and the Memory Care Director are responsible to check the QuickMAR Dashboard daily to review and validate that best practices around medication management are being followed. (See Attachment #3)

Legal Entity Representative

Marianne Bushum — Signature

Marianne Bushum Executive Dir. — Printed Name and Title

4/28/20 — Date

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☐ Not Implemented

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:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 was prescribed Ketorolac Sol 0.5%, Lotemax Sus 0.5%, Lotemax Gel 0.38%, and Ofloxacin drop 0.38% in late November and December of 2019. However, resident #1's medication administration record does not indicate the diagnosis for these medications.

Repeated Violation: 1/17/2019

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.)

Under the oversight of the former RCD, Resident #1 was missing diagnoses for all three of the medications as indicated on the communities MAR, for the months of November and December 2019. To prevent a future violation, the QuickMar system has been updated by the home's new Resident Care Director,so it will not allow approval of any medication that is added by the pharmacy, without an attached diagnosis present. Review of this topic was completed with all Wellness Nurses in the community. The Resident Care Director and Memory Care Director review all orders on an ongoing basis in order to maintain compliance.

Legal Entity Representative

Marianne Bushum — Signature

Marianne Bushum Executive Director 7/28/20 — Printed Name and Title / Date

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187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #1 was prescribed Loteprednol Sus 0.5% 4 times a day. However, resident #1 was administered this eye drop 5 times a day from 12/17/2019 through 01/05/2020 except for 12/28/2010, 12/29/2019, 01/03/2020, and 01/04/2020 when he was given 4 times as ordered. Resident #2 is prescribed Clonazepam 0.5 mg half tab but she was given Alprazolam 0.25 mg instead of the prescribed Clonazepam on 02/20/2020 at 06:53 PM.

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.)

On 01/13/20 the community self reported a med error to DHS for Resident #1. The error was discovered during an audit and review of this Resident's Physician Orders by our Regional RN Clinical Specialist, while she was visiting our community. She noted that Resident #1 was prescribed eye drops and was to have 1 drop instilled in his left eye 4 times per day; however, he was receiving the 1 drop 5 times per day. She then noted that the order had been transcribed into the pharmacy system incorrectly, and she contacted the pharmacy. Our Clinical Specialist followed up with our Wellness Nurse, who then called the Physician to have the order for the incorrect dose discontinued, and got a new order for the right dose. To prevent this violation from happening again, our Specialist made arrangements to meet with our LPN/Shift Supervisors on 01/16/20 to facilitate an in-service to review the proper procedures, and best practices related to approving orders. They also discussed the expectations regarding interactions with the pharmacy. Our Specialist also facilitated a follow-up in-service for LPN/Shift Supervisors and Med Techs on 01/29/20 to cover Medication Safety, Recording, and Incident Reporting. (See Attachments #1 and #2) On 2/21/20 the community self reported a med error to DHS for Resident #2, as Staff Member A administered the wrong PRN medication to Resident #2. Staff A was counseled, and then educated about the safety features that are part of the QuickMAR system.To prevent this violation from happening again, Med Tech staff will utilize the scanning feature as this is an added safety alert. All new orders are reviewed by nursing staff upon receipt from prescribers. Once faxed to pharmacy, all orders are stamped and put into the community Arbor Hot Box (See Attachment #5). To prevent transcription errors such as this from happening moving forward, once the first three steps are reviewed by nursing staff, the Resident Care Director and the Memory Care Director are responsible to complete the fourth and final step of the process to ensure ongoing complaince.

Legal Entity Representative

Marianne Bashem Executive Dir. 7/20/20

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