Department of Human Services
Bureau of Human Service Licensing

December 10, 2020

TRI TRAN, VP, TREASURER
CLARKS SUMMIT AID II OPCO LLC
330 N WABASH AVENUE,SUITE 3700
CHICAGO, IL 60611

RE: WILLOWBROOK PLACE
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 22659

Dear Mr. Tran,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/29/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY

Facility Information

Name: *WILLOWBROOK PLACE* **License #**: *22659* **License Expiration Date**: *01/08/2021*
Address: *150 EDELLA ROAD, CLARKS SUMMIT, PA 18411*
County: *LACKAWANNA* **Region**: *NORTHEAST*

Administrator

Name: *Mark Pisano* **Phone**: *5705866028* **Email**: *mpisano@enlivant.com, lindscott@pa.gov, mmoskalczy@pa.gov*

Legal Entity

Name: *CLARKS SUMMIT AID II OPCO LLC*
Address: *330 N WABASH AVENUE,SUITE 3700, CHICAGO, IL, 60611*
Phone: *5705866028* **Email**: *LEGALHELP@ENLIVANT.COM*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/10/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *10/29/2020*

Inspection Dates and Department Representative

10/29/2020 - On-Site: Amy Deluca, Pamela Harris

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *31*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *13* **Have Physical Disability**: *2*

Inspections / Reviews

10/29/2020 - Full

Lead Inspector: *Amy Deluca* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/27/2020*

12/4/2020 - POC Submission

Lead Reviewer: *Michele Moskalczyk* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/09/2020*

12/10/2020 - Document Submission

Lead Reviewer: *Michele Moskalczyk* **Follow-Up Type**: *Not Required*

103e - Left Overs

1. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The home's kitchen contained a package of ravioli and a packaged breakfast sandwich that were not labeled and dated when stored in the refrigerator.

Plan of Correction **Accept**

Plan of Correction:
2600.103.e

1. Dining Services Manager visualized the not labeled Ravioli and packaged breakfast sandwich on 10/29/2020 and in sight of the surveyor, removed both items.
2. A kitchen sweep was completed by the Executive Director on 10/29/2020 and no other unlabeled food was present. (See Attachment A)
3. Dining Services Manager and current Kitchen staff were educated by ED on 11/6/2020 for proper labeling of all food items. (See Attachment B)
4. QA committee reviews audits monthly of Food storage labeling and audits will be completed by Dining Services Manager and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment C)

Plan of correction. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employers, agents or other individuals who drafted or may be discussed in the responded and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.

Completion Date: *11/27/2020*

103e - Left Overs *(continued)*

Document Submission **Implemented**

Plan of Correction:
2600.103.e

1. Dining Services Manager visualized the not labeled Ravioli and packaged breakfast sandwich on 10/29/2020 and in sight of the surveyor, removed both items.
2. A kitchen sweep was completed by the Executive Director on 10/29/2020 and no other unlabeled food was present. (See Attachment A)
3. Dining Services Manager and current Kitchen staff were educated by ED on 11/6/2020 for proper labeling of all food items. (See Attachment B)
4. QA committee reviews audits monthly of Food storage labeling and audits will be completed by Dining Services Manager and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment C)

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Update - 12/10/2020

12-9-2020 On-site verification

124 - Notice to Fire Department

1. **Requirements**

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 did not have documentation of notification to the local fire department regarding the location, layout, capacity, and mobility needs of the residents in the home.

124 - Notice to Fire Department *(continued)*

Plan of Correction **Accept**

Plan of Correction:
2600.124
1. A letter was sent to the local fire department on 11/6/2020 and accepted, documenting the location, layout, capacity, and mobility needs of the residents in the home. (See Attachment D)
2. A copy of the letter that was sent on 11/6/2020 to the local fire department regarding the location, layout, capacity, and mobility needs of the residents in the home, will be kept in the Executive Director's office.
3. QA committee reviews audits monthly of Fire department documentation records and audits will be completed by Executive Director and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment E)

Plan of correction. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employers, agents or other individuals who drafted or may be discussed in the responded and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.

Completion Date: *11/27/2020*

Document Submission **Implemented**

Plan of Correction:
2600.124
1. A letter was sent to the local fire department on 11/6/2020 and accepted, documenting the location, layout, capacity, and mobility needs of the residents in the home. (See Attachment D)
2. A copy of the letter that was sent on 11/6/2020 to the local fire department regarding the location, layout, capacity, and mobility needs of the residents in the home, will be kept in the Executive Director's office.
3. QA committee reviews audits monthly of Fire department documentation records and audits will be completed by Executive Director and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment E)

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Update - 12/10/2020

12-9-2020 On-site verification

133.1 - Exit Signs

1. Requirements

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 home has an exit door leading from the dining area into a courtyard with a gate. The door is labeled as an exit on the home's posted fire evacuation diagram. At the time of the initial walk through, this exit door had a sign stating "Not an Exit" on the door.

Plan of Correction **Accept**

Plan of Correction:
2600.133.1

1. Executive Director visualized the sign stating Courtyard Not An Exit on 10/29/2020 and in sight of the surveyor, removed the sign.
2. The entire building was swept by the MT and ED on 10/29/2020, to ensure no other improper exit signage was present. (See Attachment F)
3. MT was educated by ED on 11/6/2020 on maintaining signage of evacuation routes. (See Attachment G)
4. QA committee reviews audits monthly of Exit signs labeled appropriately and audits will be completed by MT and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment H)

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Completion Date: *11/27/2020*

133.1 - Exit Signs *(continued)*

Document Submission **Implemented**

Plan of Correction:
2600.133.1

1. Executive Director visualized the sign stating Courtyard Not An Exit on 10/29/2020 and in sight of the surveyor, removed the sign.
2. The entire building was swept by the MT and ED on 10/29/2020, to ensure no other improper exit signage was present. (See Attachment F)
3. MT was educated by ED on 11/6/2020 on maintaining signage of evacuation routes. (See Attachment G)
4. QA committee reviews audits monthly of Exit signs labeled appropriately and audits will be completed by MT and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment H)

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Update - 12/10/2020

12-9-2020 On-site verification

183e - Storing Medications

1. **Requirements**

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #1's Humalog insulin pen was not dated when the pen was open for use.

183e - Storing Medications *(continued)*

Plan of Correction **Accept**

Plan of Correction:

2600.183.e

1. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not have documentation of the opening date of a Humalog insulin pen for a resident.
2. The opening date of the Humalog insulin pen was documented in sight of the surveyor, 10/29/2020. An audit was completed by the CSM on 10/29/2020 of the Med cart to ensure all open medications were labeled correctly and accurately. (See Attachment I)
3. Med Techs and nurses were educated by CSM on 11/09/2020 regarding medication labeling, 2600.183.e. (See Attachment J)
4. QA committee reviews audits monthly of medication labeled accurately and audits will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment K)

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Completion Date: *11/27/2020*

183e - Storing Medications *(continued)*

Document Submission **Implemented**

Plan of Correction:

2600.183.e

1. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not have documentation of the opening date of a Humalog insulin pen for a resident.
2. The opening date of the Humalog insulin pen was documented in sight of the surveyor, 10/29/2020. An audit was completed by the CSM on 10/29/2020 of the Med cart to ensure all open medications were labeled correctly and accurately. (See Attachment I)
3. Med Techs and nurses were educated by CSM on 11/09/2020 regarding medication labeling, 2600.183.e. (See Attachment J)
4. QA committee reviews audits monthly of medication labeled accurately and audits will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment K)

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Update - 12/10/2020

12-9-2020 On-site verification

184a - Labeling OTC/CAM

1. **Requirements**

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 has an order for Budesonide inhalation suspension to be taken two times per day. The pharmacy label on the medication did not indicate what the daily dosage of the medication was.

184a - Labeling OTC/CAM *(continued)*

Plan of Correction **Accept**

Plan of Correction:
2600.184.a

1. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not have a complete and accurate pharmacy label of an order for Budesonide inhalation, for a resident.
2. The correct labeling of the inhaler was placed on the medication in sight of the surveyor, on 10/29/2020. In addition, an audit was performed on 10/29/2020 by CSM to ensure pharmacy labels were accurate. (See Attachment L)
3. Med Techs and nurses were educated by CSM on 11/09/2020 regarding medication labeling, 2600.184.a. (See Attachment J)
4. QA committee reviews audits monthly of pharmacy label accuracy and will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment M)

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Completion Date: *11/27/2020*

184a - Labeling OTC/CAM *(continued)*

Document Submission **Implemented**

Plan of Correction:
2600.184.a

1. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not have a complete and accurate pharmacy label of an order for Budesonide inhalation, for a resident.
2. The correct labeling of the inhaler was placed on the medication in sight of the surveyor, on 10/29/2020. In addition, an audit was performed on 10/29/2020 by CSM to ensure pharmacy labels were accurate. (See Attachment L)
3. Med Techs and nurses were educated by CSM on 11/09/2020 regarding medication labeling, 2600.184.a. (See Attachment J)
4. QA committee reviews audits monthly of pharmacy label accuracy and will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment M)

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Update - 12/10/2020

12-9-2020 On-site verification

185a - Implement Storage Procedures

1. **Requirements**

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

Resident #1 requires blood glucose monitoring daily. On 10/25/20 at 2am the blood glucose reading was 163 but was recorded as 161 on the Medication Administration Record (MAR).

Resident #3 requires blood glucose monitoring daily. On 10/24/20 at 6am the blood glucose reading was 172 but was recorded as 174.

Resident #4 requires blood glucose monitoring daily. On 10/29/20 at 6am the blood glucose reading was 91 but was recorded as 99.

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

Plan of Correction:
2600.185.a
1. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not have accurate documentation of blood glucose readings for three residents.
2. An audit of all three Glucose machines was conducted by CSM on 10/29/2020 to ensure all Glucose readings were accurately documented in the MAR. (See Attachment N)
3. Med Techs and nurses were educated by CSM on 11/09/2020, regarding accurate documentation of blood glucose readings. (See Attachment J)
4. QA committee reviews audits monthly of accurate documentation of blood glucose readings and will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment O)

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Completion Date: *11/27/2020*

Document Submission **Implemented**

Plan of Correction:
2600.185.a
1. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not have accurate documentation of blood glucose readings for three residents.
2. An audit of all three Glucose machines was conducted by CSM on 10/29/2020 to ensure all Glucose readings were accurately documented in the MAR. (See Attachment N)
3. Med Techs and nurses were educated by CSM on 11/09/2020, regarding accurate documentation of blood glucose readings. (See Attachment J)
4. QA committee reviews audits monthly of accurate documentation of blood glucose readings and will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment O)

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185a - Implement Storage Procedures *(continued)*

Update - 12/10/2020

12-9-2020 On-site verification

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident #5 has an order for 25mg of Metoprolol to be held if the heart rate is less than 60. On 10/16/20 the resident's heart rate was 55 but the medication was not held according to the Medication Administration Records.

Plan of Correction **Accept**

Plan of Correction:

2600.187.d

5. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not accurately hold the medication ordered by the physician.
6. An audit was completed on 10/29/2020 by CSM, of residents who have like physician orders. (See Attachment P)
7. Med Techs and nurses were educated by CSM on 11/09/2020 regarding accurately following physician orders. (See Attachment J)
8. QA committee reviews audits monthly of accurate holds on the medication, ordered by the physician and will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment Q)

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Completion Date: *11/27/2020*

187d - Follow Prescriber's Orders *(continued)*

Document Submission **Implemented**

Plan of Correction:

2600.187.d

5. On 10/29/2020, Willowbrook Place was notified by Licensing Representative that the home did not accurately hold the medication ordered by the physician.
6. An audit was completed on 10/29/2020 by CSM, of residents who have like physician orders. (See Attachment P)
7. Med Techs and nurses were educated by CSM on 11/09/2020 regarding accurately following physician orders. (See Attachment J)
8. QA committee reviews audits monthly of accurate holds on the medication, ordered by the physician and will be completed by CSM and designee. (This will be completed weekly X4 week Bi- Monthly x1 month - then Monthly X1). Results of audit will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing. (See Attachment Q)

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Update - 12/10/2020

12-9-2020 On-site verification