Department of Human Services
Bureau of Human Service Licensing

July 22, 2021

[redacted]
701 LANSDALE OPERATING LLC
701 LANSDALE AVENUE
LANSDALE, PA 19446

RE: ST. MARY VILLA FOR INDEPENDENT
& RETIREMENT LIVING
701 LANSDALE AVENUE
LANSDALE, PA, 19446
LICENSE/COC#: 14107

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/09/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

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: *ST. MARY VILLA FOR INDEPENDENT & RETIREMENT LIVING* **License #**: *14107* **License Expiration Date**: *11/03/2021*
Address: *701 LANSDALE AVENUE, LANSDALE, PA 19446*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *2153680900* **Email**: [redacted]

Legal Entity

Name: *701 LANSDALE OPERATING LLC*
Address: *701 LANSDALE AVENUE, LANSDALE, PA, 19446*
Phone: *2153680900* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/26/1992* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *11/09/2020*

Inspection Dates and Department Representative

11/09/2020 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *66*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *St Camilus* **Capacity**: *20* **Residents Served**: *18*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

11/09/2020 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/30/2020*

1/4/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/11/2021*

7/22/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

3c - Post Current License

1. **Requirements**

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 11/9/20 the home's copy of 55 Pa.Code Chapter 2600, was not posted in a conspicuous and public place in the home.

Plan of Correction **Accept**

1. A copy of Chapter 2600 was placed where postings are located on 11/09/2020 which is a conspicuous and public are across from the nurses station.

2. An evaluation has been completed to ensure a copy of 2600 remains where postings are located across from the nurses station.
3. The Personal Care Home Administrator, Clinical Director, and Director of Community Relations will be inserviced on Chapter 2600 3c

4. An audit will be completed monthly x2 months by the Personal Care Administrator/designee to ensure the copy of 2600 remains across from the nurses' station. Audits will be reported monthly x2 months in the Quality Management Committee. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 3c

65e - 12 Hours Annual Training

1. **Requirements**

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A has no documentation of the number of training hours received for training year January 2019 to December 2019.

Plan of Correction **Accept**

1. Direct Care Staff member A has received 12 hours of annual training.
2. An evaluation of Direct Staff members training will be conducted to ensure direct care staff members complete the 12 hours of training
3. Direct staff members will sign their individual training session form after completion. Staff Development Coordinator logs each completed education in an excel spreadsheet.
4. SDC/designee will report on the education log monthly x2 months to QAPI in order to track and trend completion of 12 hours of annual training for direct staff members

Completion Date: *01/28/2021*

65e - 12 Hours Annual Training *(continued)*

Document Submission **Implemented**

See attachment 65e

65f - Training Topics

1. **Requirements**

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques during training year January 2019 to December 2019.

Plan of Correction **Accept**

1. Direct Care Staff person A received training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques

2. An evaluation of Direct Staff members training will be conducted to ensure direct care staff members complete the required training topics.

3. Direct staff members will sign individual annual inservice training session for each topic after completion. Staff Development Coordinator logs each completed annual training topic into an education tracking spreadsheet.

4. SDC/designee will report on the education log monthly x2 months to QAPI in order to track and trend completion of required training topics.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 65f

65g - Annual Training Content

1. **Requirements**

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

65g - Annual Training Content *(continued)*

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff person A did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year January 2019 to December 2019.

Staff person B did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year January 2019 to December 2019.

Plan of Correction **Accept**

Staff person A person B have received the annual training content as per Pennsylvania Regulation
2. An evaluation of Direct Staff members training has been conducted by the Staff Development Coordinator to ensure direct care staff members have completed the required annual training content as per Pennsylvania Regulation
3. Direct and Ancillary staff members will sign their individual training session form after completion of the annual training. Staff Development Coordinator logs each completed annual content training education in an excel spreadsheet.
4. SDC/designee will report on the education log monthly x2 months to QAPI in order to track and trend completion of required annual content training topics for direct care and ancillary staff members

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 65g

85a - Sanitary Conditions

1. **Requirements**

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

85a - Sanitary Conditions *(continued)*

Description of Violation

On 11/9/20 at 10:55am, a quesadilla was present in the common area kitchen refrigerator, with what appeared to be a moldy substance growing on it. The quesadilla had a date of 5/29 written on the wrappings.

On 11/9/20 at approximately 12:15pm there were three packages of hotdog buns that had a moldy substance growing on the buns.

On 11/9/20 at 4:00pm, a glucometer belonging to resident 6 had a red-brown smear of what appeared to be dried blood on the back of the glucometer.

The following instances of glucometers being shared between residents were identified during onsite inspection on 11/9/20:

- *Resident 4's glucose reading of* [redacted] *recorded on 11/07/20 at 6:30am, was found on resident 12's glucometer at 4:10am on 11/7/20.*
- *Resident 10's glucose reading of* [redacted] *recorded on 11/07/20 at 6:30am, was found on resident 12's glucometer at 4:09 am on 11/7/20*
- *Resident 11's glucose reading of* [redacted] *recorded on 11/07/20 at 6:00am, was found on resident 12's glucometer at 4:21am on 11/7/20*
- *Resident 13's Glucose reading of* [redacted] *recorded on 11/09/20 at 6:00am, was found on resident 11's glucometer at 4:32am on 11/9/20.*
- *Resident 13's Glucose reading of* [redacted] *recorded on 11/05/20 at 4:43am, was found on resident 11's glucometer at 4:43am on 11/5/20*
- *Resident 13's Glucose reading of* [redacted] *recorded on 11/04/20 at 6:00am , was found on resident 11's glucometer at 4:43am on 11/4/20*
- *Resident 14's glucose reading of* [redacted] *recorded on 11/07/20 at 6:30 am was found on resident 12's glucometer at 4:24am on 11/7/20*

85a - Sanitary Conditions *(continued)*

Plan of Correction **Accept**

85 a Sanitary Conditions
1. a. The quesadilla in refrigerator was immediately disposed of on 11/9/2020
b. The three packages of hot dog buns with the moldy substance on the buns were immediately disposed of on 11/9/2020
c. The glucometer for resident 6 was immediately cleaned on 11/9/2020.
d. Resident's glucose checks will be completed with the individual's own machine
2. a. Clinical Director will inservice 11am-7pm LPN on conducting a daily audit to ensure no out of date food remains in the refrigerator.
b. Dietary staff completed a tour of dietary to ensure dietary conditions were met.
c. Clinical Care Director cleaned the glucometers to maintain sanitary conditions.
d. Clinical Director will ensure that each resident has storage containers for glucometers and labeled with their names. Clinical Director. Clinical Care Director conducted competencies on not sharing glucometers between resident.

3 a. The 11-7 PM LPN/Designee will audit the refrigerator daily to ensure no out of date food remains in the refrigerator.
b. The Food Service/Director designee will oversee the sanitary conditions. The Food Service Director will in-service dietary staff regarding the importance of sanitary conditions in the kitchen
c. Clinical Care Director will oversee that glucometers are cleaned and stored appropriately. Clinical Care Director inserviced the LPNs and medication technicians regarding cleaning and storing glucometers appropriately.

4 The Food Service Director will audit the sanitary conditions of the kitchen as cited weekly x 4 weeks for 2 months. Clinical Care Director will audit glucometers by comparing glucometers to Medication Administration Records weekly x 4 weeks then monthly x2 months.
Results of audits will be reported to Ad hoc QAPI then summarize results in monthly QAPI meeting x2 months. to determine continuation and frequency of audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 85a

85d - Trash Receptacles

1. **Requirements**

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 11/9/20 at 12:10pm there were 3 partially full, uncovered, unattended trash cans in the kitchen by the stove and in the hallway leading to the walk-in fridge.

85d - Trash Receptacles *(continued)*

Plan of Correction **Accept**

85 D Trash Receptacles

1. The partially uncovered unattended trash cans were covered on 11/9/2020

2. The uncovered trash cans were checked to ensure trash cans had lids

3. Dietary Staff will be educated regarding covering trash cans while unattended

4. Director of Dining Services/designee will audit trash cans to ensure weekly x4 then monthly x2 per week to ensure they are covered and attended to. Director of Dining Services will report audits to monthly QAPI to ensure compliance. Results of audits will be reviewed by QAPI Committee monthly x 2 months.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 85b

86b - Bathroom

1. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in resident room 15, does not have an operable ventilation fan and there is no window in the bathroom.
The bathroom in resident room 35, does not have an operable ventilation fan and there is no window in the bathroom.
The bathroom in resident room 51, does not have an operable ventilation fan and there is no window in the bathroom.

Plan of Correction **Accept**

86B Bathroom

1. a. Room 15- The power source was relocated to another 110v source to get the bathroom ventilation working.

b. Room 35- The room was rechecked and was working

c. Room 51- The bathroom ventilation was rechecked and was working

2. All ventilations fans were checked to ensure they are functioning

3. The maintenance director will inservice maintenance staff on checking ventilation fans routinely.

4 Maintenance Director will audit weekly 4 then monthly x2 Maintenance Director will report audit to Quality Management Committee monthly. Based on the results, The Quality Management Committee will determine the continuation and frequency of the audits

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 86b

89a - Water Pressure

1. Requirements

2600.

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

89a - Water Pressure *(continued)*

Description of Violation

On 11/9/20 at 12:00pm, the home did not have sufficient hot and cold water to the bathroom sink in resident room 79. This room is occupied by a current resident.

Plan of Correction **Accept**

89a Water Pressure

1. The aerator was replaced in room 79.

2. Housekeeping Director/designee will check water pressure in Camillus resident rooms. Any issues will be reported to Maintenance and will be repaired

3. Maintenance Director will inservice Maintenance staff on checking water pressure routinely.

4. Maintenance Director will audit water pressure weekly x4 weeks then monthly x2 month. Results of audit regarding water pressure will be reported to Quality Management Committee monthly x 2 months. The Quality Management Committee will further determine the continuation and frequency of audits

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 89a

91 - Telephone Numbers

1. Requirements

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

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room 15 and 51. These rooms are occupied by current residents.

Plan of Correction **Accept**

91 Telephone Numbers

1. The emergency telephone numbers were placed by the telephone in rooms 15 and 51

2. An evaluation was completed by the Director of Community Relations of emergency telephone number either on or by the telephone.

3. PCU Staff will be inserviced regarding the importance of having emergency telephone numbers are placed by the telephone

4. Random weekly audits x4 by Personal Care Home Administrator/designee then monthly x2. Results of audits will be reported to Quality Management Committee monthly for 2 months. Based on the results of the audits, Quality Management Committee will further determine the continuation and frequency of audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 91

101j7 - Lighting/Operable Lamp

1. Requirements

101j7 - Lighting/Operable Lamp *(continued)*

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 Repeat Violation

Resident room 51 does not have access to a source of light that can be turned on/off at bedside. Room is occupied by a current resident.

Resident room 79 does not have access to a source of light that can be turned on/off at bedside. Room is occupied by a current resident.

Repeat Violation Date: 4/22/19

Plan of Correction **Accept**

101j7 Lighting/Operable Lamp
1. A light/operable lamp was placed in rooms 51 and 79 by the bedside
2. A house wide evaluation was completed by the Director of Community Relations of light/operable lamps by the bedside. Any concerns notes will be corrected.
3. PCU staff will be inserviced on the importance of having light/operable lamps by the bedside
4. Random weekly audits x4 by Personal Care Home Administrator/designee then monthly x2 Results of audits will be reported to Quality Management Committee monthly for 2 months. Quality Management Committee will determine the continuation and frequency of audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 101j7

103f - Refrigerator/Freezer Temps

1. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 11/9/20 at approximately 10:55am, the temperature in the refrigerator located in the common room kitchen was 45 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction **Accept**

103f Refrigerator/Freezer Temps
1. the refrigerator had a functioning temperature at or below 40 degrees
2. An evaluation was completed of refrigerators to ensure the temperatures are at or below 40 degrees. Refrigerators were functioning at required temperatures.
3. The night nurse was educated on the importance of checking temperatures and refrigerators having a functioning temperature of 40 degrees or below

4. A daily check of refrigerator temps will be completed by Nursing staff. The Clinical Director/designee will audit the refrigerator temperatures weekly x4 for 1 month and then monthly for 2 months. Results of audits will be reported to Quality Management Committee monthly for three months. Based on the results, Quality Management Committee will further determine the continuation and frequency of audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 103f

103g - Storing Food

1. **Requirements**

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

Description of Violation

On 11/9/20, a bag of frozen omelets in the walk in freezer was opened and unsealed.

On 11/9/20, there was a bag of hot dog buns that was opened and unsealed in the main kitchen area.

Plan of Correction **Accept**

103g Storing of Food
1 a The omelets were disposed of by Assistant Dietary Director on 11/9/2020
b. The three packages of hot dog buns were immediately disposed of on 11/9/2020
2. Food was checked for proper storage. Food was stored appropriately.
3. Dietary Staff were inserviced regarding storing food appropriately
4. Director of Dietary Services will audit food storage weekly x4 then monthly x2 Results of audits will be reported to Quality Management Committee monthly for 2 months. Quality Management Committee will determine the continuation and frequency of audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 103 f and doc103f

103i - Outdated Food

1. **Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

On 11/9/20, a quesadilla, located in the common area kitchen had a date on the wrappings of 5/29 and it appeared to be growing a moldy substance on the surface of the food.

There was an unlabeled, undated bag of frozen omelets in the walk in freezer on 11/9/20.

Plan of Correction **Accept**

103i Outdated Food

1 a. The omelets were disposed of by Assistant Dietary Director on 11/9/2020

b. The quesadilla in refrigerator was immediately disposed of on 11/9/2020

2. a Director of Dietary of Services checked frozen foods to ensure foods are properly sealed

b. Food was checked in refrigerator to ensure food was properly dated.

3. Dietary Staff were inserviced on properly dating foods.

4. The 11-7 AM LPN/Designee will audit the refrigerator daily to ensure no out of date food remains in the refrigerator.

b. Frozen foods will be audited weekly x4 weeks then monthly x2 months by Director of Dietary/designee to ensure they are properly dated. Results of audits will be reported to the Quality Management Committee monthly for 2 months. Based on the results, the Quality Management Committee will determine the continuation and frequency of audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 103i

121a - Unobstructed Egress

1. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 11/9/20 at 11:55am, a table and chair blocked egress from the home's emergency exit located to the right of the entrance in the St. Camillus Memory Care Unit.

Plan of Correction **Accept**

121a Unobstructed egress

1. Table and chair were moved to unblock egress from the home's emergency exit to the right of the entrance in the St. Camilus Memory Care Unit

2. The egress doors were checked in St. Camilus to ensure they are unblocked. All were unblocked

3. PCU staff were inserviced on ensuring egress doors remain unblocked

4. The egress doors in St. Camilus will be audited by the Personal Care Home Administrator/designee weekly x 4 then monthly x2 months Results of audits will be reported to Quality Management Committee monthly for 2 months. Quality Management Committee will determine the continuation and frequency of audits.

Completion Date: *01/28/2021*

121a - Unobstructed Egress *(continued)*

Document Submission **Implemented**

See attachment 121a

132a - Monthly Fire Drill

1. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of May 2019, November 2019, December 2019, January 2020 and February 2020.

Plan of Correction **Accept**

132a Fire Drills

1. A fire drill was held

2. Fire Drills were checked by the Personal Care Home Administrator to ensure completion

3. Maintenance staff will be in serviced on regulation. Fire Drills will be calendarized for monthly follow up

4. Personal Care Home Administrator will complete monthly audits to ensure fire drill completion as per regulation. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 132a

141a - Medical Evaluation

1. Requirements

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.

Description of Violation

Resident #1 was admitted on [redacted]. The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.

Resident #2 was admitted on [redacted]. The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the resident.

141a - Medical Evaluation *(continued)*

Plan of Correction **Accept**

141a Medical Evaluation

1. Resident #1 and Resident #2's medical evaluations were completed

2. An evaluation of new admissions since January 2020 will be completed by Clinical Director/designee to ensure timeliness of medical evaluation within 60 days prior to admission or within 30 days after admission of the resident.

3. The Clinical Director will Inservice the LPNs and Physicians regarding timely completion of Medical Evaluations within 60 days prior to admission or within 30 days after admission of the resident.

4. The Medical Evaluations of new admissions will be audited the Director of Community Relations to ensure timely completion within 60 days prior to admission or within 30 days after admission of the resident. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 141a

141a 1-10 Medical Evaluation Information

1. Requirements

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

Resident #3's medical evaluation dated [redacted] *did not include the resident's ability to self-administer medications.*

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction **Accept**

Medical Evaluation Information 141a 1-10
1. A new Medical evaluation was completed for Resident #3 to ensure it includes the resident's ability to self administer.
2. An evaluationof new admissions since January 2020 will be completed by Clinical Director/designee to ensure it includes the resident's ability to self administer.
3. The Clinical Director will inservice the LPNs and Physician's regarding the completion of medical evaluation to ensure it includes the resident's ability to self-administer.
4. The Medical Evaluations of new admissions will be audited monthly by the Clinical Director to ensure it includes the resident's ability to self-administer. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for two months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 141a1-10

141b1 - Annual Medical Evaluation

1. **Requirements**

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #4's most recent medical evaluation was completed on [redacted]

Plan of Correction **Accept**

Annual Medical Evaluation 141. b.1
1. Resident #4 had an annual medical evaluation
2. An initial house evaluation of annual medical evaluations will be completed by the Clinical Director/designee.
3. The LPNs will be inserviced by the Clinical Director to ensure timely completion of the Annual Medical Evaluation.

4. The Clinical Director will audit the Annual Medical Evaluations monthly for 2 months. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 141b1, education in previous attachments 141a and 141a1-10

181d -Storing Medication

1. **Requirements**

2600.

181d -Storing Medication *(continued)*

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #7 self-administers medications and stores medications in [redacted] room. On 11/9/20 at 11:40, there were several unlocked, unattended medications to include a bottle of Vitamin D3 50mg, Thyroxine Tab 50mcg and Amlodipine Besylate Tab 10mg in resident's bedroom and bathroom.

Plan of Correction **Accept**

181d Storing Medications

1. Resident #7's medications were secured in appropriate storage and was revaluated to self administer medications.

2. An initial house evaluation was conducted by the Clinical Director of residents who self-administer medication to ensure they are locked and secure.

3. Secure Storage will be provided to residents who self-administer.

4. Secure Storage will provided to residents who self-administer. A weekly audit x 4 and monthly x2 will be completed by the Clinical Director to ensure medications are secure The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 181d

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

On 11/9/20 there were 12 loose pills found in the medication cart for St Ann's/St Lucy's wing.

On 11/9/20 there were 7 loose pills found in the medication cart for St Camillus Memory Care wing.

On 11/9/20 there were 8 loose pills found in the medication cart for St Joseph's/St Lucy's wings.

183e - Storing Medications *(continued)*

Plan of Correction **Accept**

183e Storing Medications

1. The loose pills were destroyed by LPN in view of surveyor at the time of the findings at each medication cart

2. An initial house evaluation was conducted by the Clinical Director to ensure there were no additional loose pills in each medication cart

3. An inservice will be conducted with the LPNs by the Clinical Director on storing medications appropriately.

4. An audit will be completed by the Clinical Director weekly x4 and monthly x2 to ensure proper storage of medications. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 183e

183f - Discontinued Medications

1. **Requirements**

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 11/9/20 a bottle of Carbamide Peroxide ear drops, belonging to resident #8, was present on the medication cart. The expiration date printed on the bottle is 9/3/20.

On 11/9/20, a bottle of Saline Nasal Spray, that was not identified with a residents name, was present on the medication cart. The expiration date printed on the bottle is 1/2020.

Plan of Correction **Accept**

183f Discontinued Medications

1. The expired medications were disposed of at time of findings.

2. An initial evaluation was completed by the Clinical Director of the medication carts to identify any additional expired medications.

3. The Clinical Director will inservice the LPN's and medication technicians regarding disposing of expired medications. Weekly medication cart check will be implemented and conducted by the LPNs to identify any expired Medications.

4. The Clinical Director will conduct medication cart check audit weekly x4 then monthly x 2 months. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

183f - Discontinued Medications *(continued)*

Document Submission **Implemented**

Please see attached 183e for educations and audits

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:

Description of Violation

On 9/25/20, resident #2's, Hydrochlorothiazide 25mg tabs directions for administrations was changed to read give 0.5 tablet orally one time a day every Mon, Wed, Fri for edema. On 11/9/20, the label on the bottle reads take 1 tab by mouth once daily in the morning for 90 days. There is no notation that there is a change of directions for administration on the bottle.

The pharmacy label for resident #5's Mirtazipine 7.5mg, does not include the prescribed dosage and instructions for administration.

Plan of Correction **Accept**

184a Labeling OTC/CAM
1. A change in direction label for medication administration was placed on Resident #2's Hydrochlorothiazide bottle. Upon review, Resident #5's Mirtzipine did include the prescribed dosage and instructions for administration
2. An initial evaluation of current residents will be conducted by the Clinical Director/Designee to ensure the medication administration directions match the physician's order.
3. The Clinical Director will inservice the LPNs and Medication Technicians regarding change in direction labeling
4. Weekly audits x4 weeks for 1 month then monthly x2 months will be conducted by the Clinical Director/designee to ensure medication administration directions match the physician's order. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 184a

184b - Resident's Meds Labeled

1. **Requirements**

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

184b - Resident's Meds Labeled *(continued)*

Description of Violation

On 11/9/20, a package of DermaCerin Skin Protectant was present in the medication room of St. Camillus unit. The medication was not identified or labeled with a resident's name.

On 11/9/20, there was a bottle of Saline Nasal Spray (Sodium Chloride 0.65%) present on the St. Joseph's/St Lucy's medication cart. The medication was not identified or labeled with a resident's name.

On 11/9/20, there was a package of Gaviscon Extra Strength Antacid present on the St. Joseph's/St Lucy's medication cart. The medication was not identified or labeled with a resident's name.

Plan of Correction **Accept**

184b Resident's Meds Labeled
1. The dermacerin skin protectant, saline nasal spray and Gaviscon extra strength were disposed of at the time of findings
2. An initial evaluation of the medication carts will be conducted by the Clinical Director/designee to identify additional medications that were not labeled with a resident's name.
3. The Clinical Director will inservice the LPN's and medication technicians regarding disposing of medications that are unlabeled with the resident's name. Weekly medication cart check will be implemented and conducted by the LPNs to identify any unlabeled medications.
4. The Clinical Director will conduct medication cart check audit weekly x4 then monthly x 2 months. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 184b

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #2 is prescribed Aleve- 1 tablet by mouth every 12 hours as needed. On 11/9/20 this medication was not available in the home.

Resident #4 is prescribed Acetaminophen 325MG tab, Gaviscon 80-14.2MG chew tab, Gaviscon extra strength tablet chewable 150-105MG, Glucagon Emergency Kit 1MG, Milk of Magnesia 400MG/5ML, and Ondansetron HCI Tablet 4MG, with directions to be given at various times as needed. On 11/9/20, these medications were not present on the medication cart.

Resident #4 is prescribed glucose checks to be done three times a day before meals, scheduled for 6:30am, 11:00am and 4:30pm. The following readings for resident 4 were recorded on the MAR but there were no corresponding readings logged in [redacted] glucometer:
[redacted]/20 6:30AM [redacted], [redacted]/20 6:30AM [redacted], [redacted]/20 6:30AM [redacted], [redacted]/20 6:30AM [redacted].

Resident #6 is prescribed glucose checks to be done every Monday. The resident's MAR has a reading of [redacted] recorded on [redacted]/20 at 6:00am and [redacted] recorded on [redacted]/20 at 6:00am. These recordings are not found in resident 6's glucometer or in any other glucometer in the home.

Resident #9 is prescribed glucose checks to be done every Monday. The resident's MAR has a reading of [redacted] recorded on [redacted]/20 at 6:00am and [redacted] recorded on [redacted]/20 at 6:00am. These recordings are not found in resident 9's glucometer or in any other glucometer in the home.

Resident #10 is prescribed glucose checks three times a day before meals, scheduled for 6:30am,11:00am, and 4:30pm. On [redacted]/20, resident 10's glucose level of [redacted] is not recorded on the MAR at 6:30am.

Resident #11 is prescribed glucose checks twice daily at 6:00am and 4:00pm. The resident's MAR has a reading of [redacted] recorded on [redacted]/20 at 6am and [redacted] recorded on [redacted]/20 at 6am, but there are no corresponding readings in the resident's glucometer.

Resident #13 is prescribed glucose checks to be done twice a day at 6:00am ad 4:00pm. The following readings for resident 13 were recorded on the MAR but there are no corresponding readings logged in his/her glucometer:
[redacted]/20 6:00AM [redacted], [redacted]/20 6:00AM [redacted], [redacted]/20 6:00AM [redacted]

Resident #14 is prescribed glucose checks before meals and at bedtime and is scheduled for 6:30am, 11:00am, 4:30pm, and 8:00pm. On [redacted]/20, the resident's glucose level of [redacted], was not recorded on the residents MAR at 6:30am.

Resident #14 has a glucose reading of [redacted] recorded on their MAR for [redacted] at 11:00am, the corresponding reading in the residents glucometer is logged as [redacted]

Resident #15 is prescribed glucose checks to be done before meals on M-W-F scheduled for 6:30a, 11:00am, and 4:30pm. The following readings for resident 14 were recorded on the MAR but there are no corresponding readings logged in [redacted] glucometer:
[redacted]/20 11:00AM [redacted], [redacted]/20 6:30AM [redacted], [redacted]/20 4:30PM [redacted], [redacted]/20 6:30AM [redacted], [redacted]/20 6:30AM [redacted], [redacted]/20 11:00AM [redacted] [redacted]/20 6:30AM [redacted]

The glucometers that belong to residents 6, 9, 10, 14, and 15 are not calibrated to the correct date and time.

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

185a Implementation of Storage Procedures

1. a. Resident #2 Aleve's was discontinued due to non-use

b. Resident #4's Acetaminophen and Gaviscon were reordered. The Milk of Magnesia and Ondansetron was discontinued. The Glucagon Emergency Kit was found in the medication cart

c. Resident #4, #6, #9, #10, #11, #13, #14, #15 glucose readings and documentation cannot be retroactively corrected.

d. The glucometers for residents #6, #9, #10, #14, and #15 were recalibrated with the correct date and time.

2. An evaluation of medication availability was conducted by the Clinical Director and all medications were accounted for

b. An initial evaluation was conducted of glucometers to determine calibration status.

3. An inservice will be conducted with LPN and Medication technicians by the Clinical Director/designee to document glucometer results immediately after obtaining results, medication availability, and ensure glucometers date and times match.

4. A weekly audit of glucose meters for x 4 weeks for 1 month then monthly x2 months will be conducted by the Clinical Director to ensure medication is available, glucometer date and times match, and proper documentation of glucose check results. Results of audits will be reported the monthly x2 months at the Quality Management Committee. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 185a

187b - Date/Time of Medication Admin.

1. **Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed glucose checks [redacted] times a day before meals and is scheduled for [redacted] am, [redacted] am, and [redacted] pm. On [redacted] /20, resident #4's glucose level of [redacted] is not recorded on the MAR and the initials of the staff person who completed the glucose check at 6:35am are not recorded on the MAR.

Resident #14 is prescribed glucose checks [redacted] and at [redacted] and is scheduled for [redacted] am, [redacted] am, [redacted] pm, and [redacted] pm. On [redacted] /20, the residents glucose level of [redacted] was not recorded on the MAR and the initials of the staff person who completed the glucose check at [redacted] am are not recorded on the MAR.

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction **Accept**

187b Date/Time of Medication
1. Residents #4 and #14s glucose checks have been documented in the Medication Administration Record.
2. An initial evaluation of residents glucose check documentation in the Medication Administration Record will be conducted by the Clinical Director for the last 30 days.
3. The LPNs and medication technicians will be inserviced by the Clinical Director on documenting the glucometer results immediately after obtaining results.
4. A weekly audit x4 then monthly x2 months regarding glucometer check documentation in the Medication Administration Record will be conducted by the Clinical Director. Results of the audits will be reported to monthly for 2 months to Quality Management Committee. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

Please see attachment 185a for education and audits

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident #2 is prescribed Multivitamin [redacted] Tablet give 1 tablet by mouth one time a day. This medication was not available in the home on 11/9/20.

Resident #4 is prescribed Tradjenta 5MG Tab Give 1 tablet orally one time a day related to Type 2 diabetes. This medication was not available in the home on 11/9/20.

Resident #4 is prescribed Buspirone 5MG Tab Give 1 tablet orally two times a day. This medication was not administered on 11/5/20 at 9:00am and 6:00pm and 11/6/20 at 9:00am and 6:00pm.

Resident #5 is prescribed Minerin Cream, apply to body topically two times a day for dry skin. This medication was not available in the home on 11/29/20.

Resident #13 is prescribed glucose checks [redacted] a day at [redacted] am and [redacted] pm. On [redacted] /20 at [redacted] am there is no recorded glucose level on residents MAR and there is no corresponding reading in the residents glucometer.

Resident #15 is prescribed glucose checks to be done [redacted] meals on [redacted] scheduled for [redacted] a, [redacted] am, and [redacted] pm. On [redacted] /20 at [redacted] am there is no recorded glucose level on residents MAR and there is no corresponding reading in the residents glucometer.

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

Plan of Correction **Accept**

187d Follow Prescriber's Orders

1. a. Resident #2's multivitamin, Resident #4's tradjenta was reordered and has been receiving [redacted] buspirone. Resident #5's Minerin cream was discontinued.

b. Resident #13 and Resident #15 glucometer checks cannot retroactively corrected

2. A missed medication review of current residents in the last 30 days will be completed by the Clinical Director to ensure prescribers orders are being followed appropriately.

3. The LPNs and Medication Technicians will be inserviced by the Clinical Director regarding following precriber's orders.

4. A missed medication audit will be conducted by the Clincial Director/designee weekly x4 them monthly x2 months to ensure prescriber's orders are being followed. Results of audits will be reported the monthly Quality Management Meeting x 2 months. Based on the results of the audits, the Quality Management Committee will determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

Please see attachment 187d

225a - Assessment 15 Days

1. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident #1, who was admitted to the home on [redacted].

An assessment was not completed for resident #2, who was admitted to the home on [redacted]

An assessment was not completed for resident #5, who was admitted to the home on [redacted]

225a - Assessment 15 Days *(continued)*

Plan of Correction **Accept**

225a Assessment 15 days

1. The initial assessments for Residents #1, #2, and #5 has been completed by the Clinical Director

2. The initial assessments for new admissions in 2020 have been evaluated to ensure the initial assessment was completed within 15 days.

3. The Clinical Director will inservice the LPN regarding completing the initial assessment within 15 days as per regulation.

4. The Clincial Director will audit initial assessments monthly x2 months Quality Management Committee will review the results of initial assessments for new admissions monthly for 2 months to ensure they are completed within the first 15 days. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachment 225a

225c - Additional Assessment

1. **Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #4's current assessment was completed on [redacted]. However, the home has no record of the previous assessment.

Plan of Correction **Accept**

225c Additional Assessment

1. The additional assessment for [redacted] was completed and placed in the chart.

2. An initial house evaluation of additional assessments has been completed by the Clinical Director/designee.

3. The LPNs will be inserviced by the Clinical Director to ensure timely completion of the additional assessment.

4. The Clinical Director will audit the additional assessment monthly for 2 months to ensure additional assessments are completed. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

Please see attachment 225a

227a - Support Plan 30 Days

1. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on [redacted]; however, the resident's initial support plan was not completed.
Resident #2 was admitted on [redacted]; however, the resident's initial support plan was not completed.
Resident #5 was admitted on [redacted]; however, the resident's initial support plan was not completed.

Plan of Correction **Accept**

227a Support Plan 30 Days

1. The initial support plans for Residents #1, #2, and #5 has been completed

2. The initial support plans for new admissions in 2020 have been evaluated to ensure the initial support plan was completed within the first 30 days of admission

3. The Clinical Director will inservice the LPNs on completing the initial support plans within 30 days of admission

4. The Clinical Director will audit the initial supports plans monthly x 2 month to ensure they are completed within 30 days of admission. Quality Management Committee will review the results of initial support plans for new admissions monthly x 2 months to ensure they are completed within the 30 days of admission. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

Please see attachment 225a

231e - No Objection Statement

1. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Repeat Violation

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Repeat Violation date: 9/17/19 et al.

231e - No Objection Statement *(continued)*

Plan of Correction **Accept**

231e No Objection Statement

1. Resident #5 and designated person has signed the no objection statement.

2. Director of Community Relations has evaluated the No Objection Statements for St. Camilus residents to ensure they are completed

3. New Director of Community Relations will be inserviced on this regulation.

4. New admissions or transfers to St. Camilus memory care will be audited by the Director of Community Relations post admission to ensure the no objection statement has been completed. The results of monthly audits will be reported to the Quality Management Committee meeting monthly for 2 months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 231e

234a - Admission Support Plan

1. **Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was not completed.

Plan of Correction **Accept**

234a Admission Support Plan

1. The initial support plan for Resident #5 has been completed

2. The initial support plans for new admissions or transfers to St. Camilus memory care unit for 2020 has been evaluated to ensure the admission support plan was completed within the first 72 hours of admission

3. The Personal Care Home Administrator will inservice the Clinical Director on completing the initial support plans for new admissions or transfers to the St. Camilus memory care unit within the first 72 hours of admission.

4. The admission support plans will be audited by to ensure timely completion of admissions support plans within 72 hours of admission. Quality Management Committee will review the results of admission support plan audit for new admissions or transfers to the St. Camilus secured memory care unit monthly x 2 months to ensure they are completed within the first 72hrs.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachments 234a and resident #5 234a

236 - Staff Training

1. **Requirements**

2600.

236 - Staff Training *(continued)*

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had no documentation of hours of training in dementia care during the January 2019 to December 2019 training year.

Plan of Correction **Accept**

236 Staff Training

1. Direct Care Staff Person A has been trained related to dementia care and services.

2. An evaluation of Direct Staff members training will be conducted to ensure direct care staff members complete training related to demential care and services

5. Direct staff members will sign their individual annual dementia training session form after completion. Staff Development Coordinator logs each completed education in an excel spreadsheet.

6. SDC/designee will report on the education log monthly x2 months to the Quality Management Committee in order to track and trend the timely completion of 6 hours of annual training related to dementia care and services.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attached 236

252 - Record Content

1. **Requirements**

2600.

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

7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.

Description of Violation

Resident #1, #2, #4, and #5's record does not include the current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.

Resident #4's record does not include a photograph of the resident that is no more than 2 years old.

252 - Record Content *(continued)*

Plan of Correction **Accept**

252 Record Content

1. Residents #1, #2, #4, and #5's physicians examination reports including medical evaluations have been placed on the charts. A new photograph of resident #4 has been obtained

2. An initial house evaluation has been conducted by the Clinical Director/designee to ensure current residents physician examination reports including copies of the medical evaluation forms are included in each resident record and of photographs of residents.

3. The Director of Community Relations and The Clinical Director will be inserviced regarding this regulation.

4. Clinical Director/designee will conduct an audit monthly x2 months of physician examinations including medical evaluations to ensure they are in the record and photographs to ensure they are not more than 2 years old. The Clincial Director/designee will report the audits to the Quality Management Committee monthly x 2months. Based on the results of the audits, the Quality Management Committee will further determine the continuation and frequency of the audits.

Completion Date: *01/28/2021*

Document Submission **Implemented**

See attachments 141 for medical evaluations and see attachment 252 resident photo

Department of Human Services
Bureau of Human Service Licensing

July 22, 2021

[redacted]
701 LANSDALE OPERATING LLC
701 LANSDALE AVENUE
LANSDALE, PA 19446

RE: ST. MARY VILLA FOR INDEPENDENT & RETIREMENT LIVING
701 LANSDALE AVENUE
LANSDALE, PA, 19446
LICENSE/COC#: 14107

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

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: *ST. MARY VILLA FOR INDEPENDENT & RETIREMENT LIVING* **License #**: *14107* **License Expiration Date**: *11/03/2021*
Address: *701 LANSDALE AVENUE, LANSDALE, PA 19446*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *2153680900* **Email**: [redacted]

Legal Entity

Name: *701 LANSDALE OPERATING LLC*
Address: *701 LANSDALE AVENUE, LANSDALE, PA, 19446*
Phone: *2153680900* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/26/1992* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Monitoring,Interim* **Exit Conference Date**: *03/26/2021*

Inspection Dates and Department Representative

03/26/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *56*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *St Camillus Wing* **Capacity**: *20* **Residents Served**: *17*

Hospice

Current Residents: -

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

03/26/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/30/2021*

5/19/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/26/2021*

7/22/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

On 3/26/21 there was a drop of dried brownish red fluid present on the container used to store the glucometer assigned to resident #4.
The following instances of glucometers being shared between residents were identified during onsite inspection on 3/26/21:

- *Resident #1's glucose reading of [redacted] recorded on [redacted] at [redacted]pm, was found on resident #3's glucometer at [redacted]pm on [redacted]/21.*
- *Resident #2's glucose reading of [redacted] recorded on [redacted]/21 at [redacted]am, was found on resident #5's glucometer at [redacted]am on [redacted]/21.*
- *Resident #3's glucose reading of [redacted] recorded on [redacted]/21 at [redacted]am, was found on resident #1's glucometer at [redacted]am on 3/25/21.*
- *Resident #4's glucose reading of [redacted] recorded on [redacted]/21 at [redacted]0pm, was found on resident #2's glucometer at [redacted]pm on [redacted]/21.*

Plan of Correction **Accept**

1.
a. the glucometer assigned to resident #4 was immediately cleaned on 3.26.21
b. Resident's glucose checks will be completed with the individual's own machine
2.
a. The Clinical Director cleaned the glucometers to maintain sanitary conditions
b. Clinical director will ensure that each resident has storage containers for glucometers and labeled with their names. Clinical care director conducted competencies on not sharing glucometers between residents
3.
a. Clinical care director will oversee that the glucometers are cleaned and stored appropriately. Clinical care director inservices the LPNs and medication technicians regarding cleaning and storing glucometers appropriately.
4.
a. the clinical director will audit glucometers by comparing glucometer to Medication Administration records weekly x4 then one month. Results of audits will be submitted to QAPI for review

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

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

On 3/26/21, there was an unlabeled, undated plastic bag containing food items in the kitchenette refrigerator.

103e - Left Overs *(continued)*

Plan of Correction **Accept**

1.the unlabeled undated plastic bag containing food items was discarded.
2. b. Food was checked in refrigerator to ensure food was properly dated.
3. Staff were inserviced on properly labeling foods.
4. a. The 11-7 staff will audit the refrigerator daily to ensure no out unlabeled food remains in the refrigerator.
b. Refrigerator will be audited weekly X4 for one month by Director of dining/ designee to ensure properly labeled food. Results of audits will be submitted to QAPI for review.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

103i - Outdated Food

1. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 3/26/21 a styrofoam container of left over food marked with a date of 3/7/21 observed in the refrigerator of the kitchenette. The food items appeared spoiled upon inspection.

Plan of Correction **Accept**

1.
a. the Styrofoam container of leftover food was discarded by the Executive Director.

2. b. Food was checked in refrigerator to ensure food was properly dated.

3. Staff were inserviced on properly dating foods.

4. a. The 11-7 staff will audit the refrigerator daily to ensure no out of date food remains in the refrigerator.

b. Refrigerator will be audited weekly X4 for one month by Director of dining/ designee to ensure properly dated food. Results of audits will be submitted to QAPI for review.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

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.

183e - Storing Medications *(continued)*

Description of Violation

On 3/26/21, at total of 7 loose pills were observed throughout the St. Camillus Memory Care medication cart.
On 3/26/21, at total of 3 loose pills were observed throughout the St Annes/St Lucy's medication cart.
On 3/26/21, 1 loose pill was observed in the St. Joseph's/St. Anne's medication cart.

Plan of Correction **Accept**

1. The expired medications were disposed of at the time of findings
2. An initial evaluation was completed by the Clinical Director of the medication carts to identify any additional expired medications.
3. The Clinical Director will inservice the LPNs and Medication Technicians regarding disposing of expired medications.
4. The Clinical Director will conduct medication cart checks weekly X4 for one month. The results will be submitted to QAPI.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

183f - Discontinued Medications

1. **Requirements**

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The following medication, Acetaminophen 325mg, belonging to resident #6 was observed in the St Anne's/St Lucy's medication cart. The bottle had a manufacturers expiration date of 1/2021 printed on the bottle.

Plan of Correction **Accept**

1. The expired medications were disposed of at the time of findings
2. An initial evaluation was completed by the Clinical Director of the medication carts to identify any additional expired medications.
3. The Clinical Director will inservice the LPNs and Medication Technicians regarding disposing of expired medications.
4. The Clinical Director will conduct medication cart checks weekly X4 for one month. The results will be submitted to QAPI.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

185a - Implement Storage Procedures

1. **Requirements**

185a - Implement Storage Procedures *(continued)*

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 is prescribed glucose checks twice daily at 6am and 4pm. Resident #1 is also prescribed a sliding scale for insulin administration. Resident #1 has the following mismatched readings recorded on their MAR.

- *On [redacted] at [redacted] the glucometer reads [redacted]: the MAR is recorded as [redacted]*
- *On [redacted] at [redacted] the glucometer reads [redacted]2: there is no recorded level on the MAR*
- *On [redacted] at [redacted] the glucometer reads [redacted]: there is no recorded level on the MAR*
- *On [redacted] at [redacted] the glucometer reads [redacted]: there is no recorded level on the MAR*
- *On [redacted] at [redacted] the glucometer reads [redacted]: the MAR is recorded as [redacted]*
- *On [redacted] at [redacted] the glucometer reads [redacted]: there is no recorded level on the MAR*
- *On [redacted] at [redacted] the glucometer reads [redacted]: there is no recorded level on the MAR*
- *On [redacted] at [redacted] the glucometer reads [redacted]: the MAR is recorded as [redacted]*

Resident #2 is prescribed glucose checks three times a day before meals, scheduled for 6:30am,11:00am, and 4:30pm. Resident has a sliding scale for insulin administration.

- *On [redacted], resident #2's glucose level of [redacted] is not recorded on the MAR at [redacted] am.*
- *On [redacted], resident #2's glucose level of [redacted] is not recorded on the MAR at [redacted] am.*

Resident #3 is prescribed glucose checks two times a day, scheduled for 6:00am, and 4:00pm.

- *On [redacted], resident #3's glucose level of [redacted] is not recorded on the MAR at [redacted] am.*
- *On [redacted] at [redacted] the glucometer reads [redacted]: the MAR is recorded as [redacted]*
- *On [redacted], resident #3's glucose level of [redacted] is not recorded on the MAR at [redacted].*
- *On [redacted] at [redacted] the glucometer reads [redacted]: the MAR is recorded as [redacted]*

Resident #5 is prescribed glucose checks 4 times a day, scheduled at 6:30am, 11am, 4:30pm and 8:00pm. Resident #5 is also prescribed a sliding scale insulin administration. Resident #5 has the following mismatched readings logged on their MAR:

- *[redacted] at [redacted]0am- glucometer reads [redacted]; MAR is recorded as [redacted]*
- *[redacted] at [redacted]am- glucometer reads [redacted]; MAR is recorded as [redacted]*
- *[redacted] at [redacted]am- glucometer reads [redacted]; MAR is recorded as [redacted]*
- *[redacted] at [redacted]am- glucometer reads [redacted]; MAR is recorded as [redacted]*
- *[redacted] at [redacted]am- glucometer reads [redacted]: there is no recording on the MAR*

Resident #6 is prescribed Polyethyline Glycol- give 17gram orally every 24 hrs as needed for constipation, Milk of Magnesia- Give 30ml by mouth every 24 hours as needed for constipation, Bisacodyl 10mg Suppositories- insert 1 suppository rectally every 24hrs as needed for constipation. On 3/26/21 these medications were not present on the medication cart and therefore not available for the resident if needed.

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

1

a. Resident #1, #2, #3, #5 glucose readings and documentation can not be retroactively corrected

b. Resident #6 Polyethyline Gycol, Milk of Magnesia and Bisacodyl have been discontinued due to non-use.

2. An evaluation of medication availability was conducted by the Clinical Director and all medications are available for administration.

3. An inservice will be conducted with LPN and Medication technicians by the Clinical Director/ Designee to document glucometer results immediately after obtaining results and medication availability.

4. A weekly audit of glucose meters X4 weeks for one month will be conducted by the Clinical Director to ensure medications are available and proper documentation of glucose check results. Results of audit will be submitted to QAPI.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

187d - Follow Prescriber's Orders

1. **Requirements**

2600.

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

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

Description of Violation

Resident #1 is prescribed glucose checks twice a day at 6:00am and 4:00pm and is prescribed a sliding scale insulin administration based on the residents glucose level.

- *On 3/14 at 4:00pm there is no recorded glucose level on resident #1's MAR, there is no corresponding reading in the residents glucometer, and the resident was not administered insulin.*
- *On 3/3 at 6:00am there is no recorded glucose level on resident #1's MAR, there is no corresponding reading in the residents glucometer, and the resident was not administered insulin.*

Resident #2 is prescribed glucose checks three times a day at 6:30am and 4:30pm and is prescribed a sliding scale insulin administration based on the residents glucose level. Sliding Scale as follows: 151-200= 4 units, 201-250= 6 units, 251-300= 8 units, 301-350= 10 units, 351-400= 12 units and call doctor if under 60 or over 400.

- *On [redacted] at [redacted]am the residents glucose meter has a recorded level of [redacted]. The residents MAR Is recorded with a level of [redacted] and [redacted] units of insulin were administered. Based on the resident's reading in the glucometer, the resident should have received no units of insulin.*
- *On [redacted] at [redacted]pm the residents glucose meter has a recorded level of [redacted]. The residents [redacted] Is recorded with a level of [redacted] and [redacted] units of insulin were administered. Based on the resident's reading in the glucometer, the resident should have received [redacted] units of insulin.*
- *On [redacted] at [redacted]0pm the residents glucose meter has a recorded level of [redacted]. The residents MAR Is recorded with a level of [redacted] and [redacted] units of insulin were administered. Based on the resident's reading in the glucometer, the resident should have received [redacted] units of insulin.*
- *On [redacted] at [redacted]am the residents glucose meter has a recorded level of [redacted] The residents MAR Is recorded with a level of [redacted]85 and [redacted] units of insulin were administered. Based on the resident's reading in the glucometer, the resident should have received [redacted] units of insulin.*

Resident #8 is prescribed glucose checks one a week scheduled on [redacted].

- *On [redacted] there is no recorded glucose level on resident 7's MAR, there is no corresponding reading in the residents glucometer.*
- *On [redacted] there is no recorded glucose level on resident 7's MAR, there is no corresponding reading in the residents glucometer.*

Resident #6 is prescribed Vitamin B-1, give one tablet orally in the morning for supplement. This medication is not present on the medication cart on 3/26/21.

Resident #7 is prescribed Xarelto Tablets 20mg-Give 1 tablet by mouth at bedtime for afib, and Atorvastatin- give 1 tablet by mouth at bedtime for hyperlipidemia. These medications were not administered to resident 7 on 3/14/21.

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

Plan of Correction **Accept**

1

a. Resident #1, #2, and #8 insulin administration cannot be retroactively corrected.

b. Resident #6 has Vitamin B-1 available in the medication cart for administration.

c. Resident #7 Xarelto and Atorvastatin documentation can not be retroactively corrected.

2.

a. An initial evaluation of resident glucose check documentation in the medication administration record will be conducted by the clinical director for the last 30 days.

b. The Clinical Director will complete an audit of all ordered medications for availability.

c. The Clinical Director will review audit all MARS for the month of April to verify documentation of administration.

3. The LPNs and medication techs will be inserviced by the Clinical Director on documenting the glucometer results immediately after obtaining results

4. A weekly audit X4 for one month regarding glucometer check documentation in the Medication Administration Record will be conducted by the Clinical Director. Results of the audits will be submitted to QAPI.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

224a - Preadmission Screen Form

1. **Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #7 was admitted to the home on [redacted]; however, there is no preadmission screening form of file for the resident.

Resident #9 was admitted to the home on [redacted] however, there is no preadmission screening form of file for the resident.

Plan of Correction **Accept**

1.Resident #7 and Resident # 9 Preadmission screening cannot be completed retroactively.

2. & 3 Clinical Director has been educated on completion of cognitive preadmission screening.

4. New admission or transfer to St. Camillus memory care will have Preadmission screening completed within 72 hours prior to admission. Executive Director/Designee will audit monthly X 2 months. The results of the audits will be submitted to QAPI.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

231b - Medical Evaluation

1. **Requirements**

2600.

231b - Medical Evaluation *(continued)*

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

A medical evaluation for resident #9, who was admitted to the SDCU on [redacted] was not completed within 60 days prior to admission.

Plan of Correction **Accept**

1. Resident #9 medical evaluation cannot be completed retroactively.

2. and 3. Clinical Director has been educated on completion of Medical Evaluation

4. New admissions will have Medical Evaluation completed within 60 days prior to admission. Executive Director/Designee will audit monthly X2. The audits will be submitted to QAPI.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachments

231c - Preadmission Screening

1. **Requirements**

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 #7 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, resident #7's written cognitive preadmission screening was not completed.

Resident #9 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, resident #9's written cognitive preadmission screening was not completed.

Plan of Correction **Accept**

1. Resident #9 and Resident #7 cognitive preadmission screening cannot be completed retroactively.

2. and 3. Clinical Director has been educated on completion of cognitive Preadmission screening

4. New admissions to SDCU will have cognitive Preadmission screenings completed within 72 hours prior to admission. Executive Director/Designee will audit monthly X2. The audits will be submitted to QAPI.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachment

231e - No Objection Statement

1. **Requirements**

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

231e - No Objection Statement *(continued)*

Description of Violation

Resident #9 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction **Accept**

1. Resident #5 and designated person has signed the no objection statement.
2. Director of Admissions has audited all the residents in St Camillus for no objection statements. She has obtained signatures as needed.
3. Director of Admissions has been educated on this regulation.
4. New admissions or transfers to Camillus will be audited by the Executive Director for No Objective Statement signature. Results will be submitted to QAPI for review.

Completion Date: *06/03/2021*

Document Submission **Implemented**

see attachment