**Department of Human Services**
**Bureau of Human Service Licensing**

April 1, 2021

[redacted] ADMINISTRATOR
HIDDEN MEADOWS OPCO LLC
1751 PINNACLE DRIVE, 6TH FLOOR
TYSONS CORNER, VA 22102

RE: HIDDEN MEADOWS ON THE RIDGE
THE LAURELS
340 FARMERS LANE
SELLERSVILLE, PA, 18960
LICENSE/COC#: 14524

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

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**: *HIDDEN MEADOWS ON THE RIDGE THE LAURELS* **Licen e #**: *14524* **Licen e Expiration Date**: *07/20/2021*
**Addre :** *340 FARMERS LANE, SELLERSVILLE, PA 18960*
**County**: *BUCKS* **Region**: *SOUTHEAST*

## Administrator

**Name**: **Phone**: *2152576701* **Email**:

## Legal Entity

**Name**: *HIDDEN MEADOWS OPCO LLC*
**Address:** *1751 PINNACLE DRIVE, 6TH FLOOR, TYSONS CORNER, VA, 22102*
**Phone**: *2152576701* **Email**:

## Certificate(s) of Occupancy

**Type**: *I-2* **Date**: *03/05/2014* **Issued By**: *L&I*

## Staffing Hours

**Re ident Support Staff**: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

## Inspection

**Type**: *Full* **Notice**: *Unannounced* **BHA Docket #**:
**Reason**: *Renewal* **Exit Conference Date**: *01/26/2021*

## Inspection Dates and Department Representative

*01/26/2021 - On-Site:*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *50* **Residents Served**: *27*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *BTR* **Capacity**: *50* **Residents Served**: *27*

### Hospice

**Current Residents**: *2*

### Number of Residents Who:

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

## Inspections / Reviews

### 01/26/2021 Full

**Lead Inspector**: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/18/2021*

## Inspections / Reviews *(continued)*

### 2/19/2021 - POC Submission

**Lead Reviewer:** [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *02/22/2021*

### 2/24/2021 POC Submi ion

**Lead Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/15/2021*

### 4/1/2021 - Document Submission

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

## 25b - Contract Signatures

1. **Requirements**

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident s designated person if any, if the resident agrees.

**Description of Violation**

*The resident home contract, dated 09/24/20, for resident #1 was not signed by the resident.*

**Plan of Correction** — **Do Not Accept**

*Due to residents cognitive abilities, ██ is unable to sign ██ contract. ██ son however did. Going forward, attempts will be made for residents to sign contracts, if they are unable notation will be made on the contract. HMOR policy has been updated to reflect the procedure for residents refusals or inabilities to sign these documents.*

**Completion Date:** *02/18/2021*

**Plan of Correction** — **Accept**

*Due to residents cognitive abilities, ██ is unable to sign ██ contract. ██ son however did. Going forward, attempts will be made for residents to sign contracts, if they are unable notation will be made on the contract. HMOR policy has been updated to reflect the procedure for residents refusals or inabilities to sign these documents.*
*All Laurels Contracts have been audited to ensure compliance and further compliance will be monitored by the ED monthly*

**Completion Date:** *02/22/2021*

**Document Submission** — **Implemented**

*All contracts have been audited and we are in compliance of this regulation. See attached File audit form*

## 28f Resident's Funds and 30 day Refund

1. **Requirements**

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

**Description of Violation**

*Resident #2 was discharged on ██████. The home did not provide the required refund.*

**Plan of Correction** — **Accept**

*Resident #2 was not owed any monies after discharge. However, this was not documented in ██ chart. Going forward, refunds and timeliness will be documented and maintained in his/her file after discharge. Please see attached Move out form. Compliance will be monitored by the Business Office Manager monthly.*

**Completion Date:** *02/12/2021*

**Document Submission** — **Implemented**

*New business office manager has been trained on Move out Form (attached) and ED will continue to monitor compliance. Move outs are reviewed daily during leadership stand up meeting (see attached agenda)*

## 51 - Criminal Background Check

1. **Requirements**

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

**Description of Violation**

*Agency Staff A, hired on [redacted] did not have a criminal background check completed.*

**Plan of Correction** **Accept**

*t is not standard practice for HMOR to utilize agency staffing. However during this time, it was necessary for COVID reasons.*

*All HMOR staff have criminal background checks completed at time of hire, as well as any other outside service providers who provide services to our residents.*

*f for any reason, agency staff are required again, the agency company must show proof of background check and it will be kept in our records at time of scheduling, prior to the person entering our building. Compliance will be monitored by Director of Wellness and the Executive Director on an as needed or monthly basis.*

**Completion Date:** *02/12/2021*

**Document Submission** **Implemented**

*All employee files have been audited and we are in compliance of this regulation*

## 65a - FS Orientation 1st Day

1. **Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

**Description of Violation**

*Agency Staff person A, whose first day of work was [redacted] did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.*

## 65a - FS Orientation 1st Day *(continued)*

**Plan of Correction** **Accept**

*It is not standard practice for HMOR to utilize agency staffing. However during this time, it was necessary for COVID reasons.*
*All HMOR staff are trained upon hire of the above topics, unfortunately, this person who was not an HMOR employee, did not. However, at any time going forward, if we have agency persons on the schedule, we will provide training when they report on shift by a HMOR staff person. Please see the attached acknowledgment form. This will be monitored for compliance by the DHW and ED monthly*

**Completion Date** *02/17/2021*

**Document Submission** **Implemented**

*All employee files have been audited and we are in compliance of this regulation*

## 65b - Rights/Abuse 40 Hours

1. **Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

*Agency Staff person A completed his/her 40th scheduled work hour on 1/26/21. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102), reporting of reportable incidents and conditions.*

**Plan of Correction** **Accept**

*It is not standard practice for HMOR to utilize agency staffing. However during this time, it was necessary for COVID reasons.*
*All HMOR staff are trained upon hire of the above topics, unfortunately, this person who was not an HMOR employee, did not. However, at any time going forward, if we have agency persons on the schedule, we will provide training when they report on shift by a HMOR staff person. Please see the attached acknowledgment form. This will be monitored for compliance by the DHW and ED monthly*

**Completion Date:** *02/17/2021*

**Document Submission** **Implemented**

*All employee files have been audited and we are in compliance of this regulation*

## 82c - Locking Poisonous Materials

1. **Requirements**

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

## 82c - Locking Poisonous Materials *(continued)*

**Description of Violation**

*A tube of Colgate toothpaste with a manufacture's label indicating "in case of accidental ingestion, seek professional assistance", was unlocked, unattended, and accessible to residents. Not all the residents of the home, including all residents in Memory Care, have been assessed capable of recognizing and using poisons safely.*

**Plan of Correction** **Do Not Accept**

*All staff have been re-educated about poisonous materials in the memory care facility. Staff retrieve materials needed for direct care from locked cabinet, and are to return when completed. Compliance will be monitored by Executive Director monthly.*
*Please see attached memo distributed to Laurels staff members*

**Completion Date:** *02/17/2021*

**Plan of Correction** **Accept**

*All staff have been re-educated about poisonous materials in the memory care facility. Staff retrieve materials needed for direct care from locked cabinet, and are to return when completed. Each shift is to initial off completion of room safety checks after each shift. Shift supervisors will monitor compliance at each shift.*
*Please see attached memo distributed to Laurels staff members. Please see updated Laurels communication log sheet.*

**Completion Date:** *02/22/2021*

**Document Submission** **Implemented**

*Rooms are being checked daily by staff, DHW continue to monitor for compliance*

## 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 1 is prescribed ASPIRIN LOW Tab 81mg, CLOPIDOGREL Tab 75mg, LISINOPRIL Tab 2.5mg, METOPROLOL SUC Tab 25mg ER, SERTRALINE Tab 50mg and VITAMIN D3 2000 Unit, give 1 tablet one time a day. Resident 1's 01/2021 medication administration record does not include the initials of the staff person who administered medications on 1/14/21 at 8 am.*

*Resident 1 is prescribed ATORVASTATIN TAB 80mg and Donepezil Tab 25mg, give 1 tablet orally one time a day Resident 1's 01/2021 medication administration record does not include the initials of the staff person who administered medications on 1/04 and 1/23 at 4 pm.*

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

**Plan of Correction** **Do Not Accept**

*Documentation of administration was corrected. Going forward, all staff have been retrained as to reviewing MARs at end of shift to ensure all medications were signed out.*
*Night time nursing staff have been assigned nightly MAR audits and Director of Wellness will monitor compliance on a monthly basis.*

**Completion Date:** *02/12/2021*

**Update - 02/19/2021**

*Frequency of compliance audits is insufficient. More frequent checks will be needed initially to ensure compliance with a gradual reduction in monitoring as compliance is demonstrated.*

**Plan of Correction** **Accept**

*Documentation of administration was corrected. Going forward, all staff have been retrained as to reviewing MARs at end of shift to ensure all medications were signed out.*
*Staff are to audit MARs at the end of each shift, nightly audits to be conducted by nursing staff and Director of Wellness will monitor compliance on a monthly basis.*

**Completion Date:** *02/22/2021*

**Document Submission** **Implemented**

*Please see recent monthly cart/medication audit form to monitor for compliance*

## 227h - Support Plan Refuse Sign

1. **Requirements**

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

**Description of Violation**

*Resident #1 participated in the development of his/her support plan on 9/30/20. The resident was unable to sign the support plan. The home did not make a notation regarding the resident's inability to sign.*

**Plan of Correction** **Do Not Accept**

*Resident #1's support plan was reviewed with resident and ██ representative. ██ family representative sign, however due to residents cognitive capabilities, ██ did not. Please see corrected RASP showing documentation that resident is unable to sign. Going forward, DHW will monitor compliance monthly*

**Completion Date:** *02/17/2021*

**Plan of Correction** **Accept**

*Resident #1's support plan was reviewed with resident and ██ representative. ██ family representative sign, however due to residents cognitive capabilities, ██ did not. Please see corrected RASP showing documentation that resident is unable to sign.*
*DHW and care coordinator have reviewed regulation 2600.227h and going forward, DHW will monitor compliance monthly.*

**Completion Date:** *02/22/2021*

## 227h - Support Plan Refuse Sign *(continued)*

**Document Submission** **Implemented**

*Please see attached monthly file and rasp review to monitor for compliance*

## 231b - Medical Evaluation

1. **Requirements**

2600.

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**

*Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation was completed on 06/11/20.*

**Plan of Correction** **Do Not Accept**

*Resident was admitted to the SDCU on [redacted] and was seen by MD on 6/11/20 unfortunately this was 3 days later than required. Laurels staff persons going forward will ensure timely medical evaluations. This will be monitored by the DHW on a monthly basis and reviewed at QMP annually*

**Completion Date:** *02/18/2021*

**Plan of Correction** **Accept**

*Resident was admitted to the SDCU on [redacted] and was seen by MD on 6/11/20 unfortunately this was 3 days later than required. To ensure timely DME completion, DHW and Care Coordinator have set up a calendar/tickler system. Both the DHW and care coordinator have reviewed regulation 2600.231.b This will be monitored by the DHW on a monthly basis and reviewed at QMP annually*

**Completion Date:** *02/22/2021*

**Document Submission** **Implemented**

*Please see attached file review, residents files are reviewed monthly to ensure compliance*

## 233b - Lock Manufacturer Statement

1. **Requirements**

2600.

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
   1. Upon a signal from an activated fire alarm system, heat or smoke detector.
   2. Power failure to the home.
   3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

**Description of Violation**

*The home does not have a statement from the manufacturer of the Marco Protection Systems, LLC verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.*

## 233b - Lock Manufacturer Statement *(continued)*

**Plan of Correction** **Accept**

*Please see attached Letter from Marco Protection Systems as well as letter from West Rockhill Township.*

*Going forward HMOR the Laurels will maintain these letters for their records at all times. Director of Facilities and Executive Director will both audit for compliance on an annual basis, which will be reviewed in our QM meetings*

**Completion Date:** *02/12/2021*

**Update - 02/19/2021**

**Document Submission** **Implemented**

*Letter has been submitted to the department, no further action needed at this time. However, letter is maintained in DHS ready binder and will be checked annual to ensure it is accessible by agency representatives*

## 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 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on 06/24/20.*

*Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on 09/30/20.*

**Plan of Correction** **Do Not Accept**

*Residents support plans were not completed within the appropriate timeframes. Laurels care planning staff were re-educated on timeliness of RASPs and will ensure timely completions. DHW will monitor for compliance monthly and will be reviewed annually with the ED during QM meetings*

**Completion Date:** *02/18/2021*

**Plan of Correction** **Accept**

*Residents support plans were not completed within the appropriate timeframes. Laurels care planning staff were re-educated on timeliness of RASPs and in an effort to ensure timeliness of RASPs have set up a calendar/tickler system for tracking when due. DHW will monitor for compliance monthly and will be reviewed annually with the ED during QM meetings*

**Completion Date:** *02/22/2021*

**Document Submission** **Implemented**

*Resident charts and RASPs are reviewed monthly to monitor for compliance, please see attached review form and audit form*