Department of Human Services
Bureau of Human Service Licensing

March 9, 2021

[REDACTED] ADMINISTRATOR
FIVE STAR QUALITY CARE NS OPERATOR LLC
400 CENTRE STREET
ATTN: LICENSING
NEWTON, MA 2458

RE: THE DEVON SENIOR LIVING
445 NORTH VALLEY FORGE ROAD
DEVON, PA, 19333
LICENSE/COC#: 13206

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/08/2021, 02/09/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Shawn Parker

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: *THE DEVON SENIOR LIVING* **Licen e #**: *13206* **Licen e Expiration Date**: *11/06/2021*
Addre : *445 NORTH VALLEY FORGE ROAD, DEVON, PA 19333*
County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *6102632300* **Email**: [redacted]

Legal Entity

Name: *FIVE STAR QUALITY CARE NS OPERATOR LLC*
Address: *400 CENTRE STREET, ATTN: LICENSING, NEWTON, MA, 2458*
Phone: *6102632300* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/02/2003* **Issued By**: *COPA Dept of L&I*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *02/09/2021*

Inspection Dates and Department Representative

02/08/2021 - On-Site: [redacted]
02/09/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *47*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Bridges to Rediscovery* **Capacity**: *26* **Residents Served**: *12*

Hospice

Current Re ident : *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *17* **Have Physical Disability**: *1*

Inspections / Reviews

02/08/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *03/01/2021*

3/1/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/08/2021*

3/9/2021 - Document Submission

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

18 - Compliance With Laws

1. **Requirements**

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Carbon Monoxide Alarms Standards Act indicates that carbon monoxide detectors are to be placed in close proximity of, but not less than 15 feet from, any fossil fuel burning device or appliance. On 2/8/2021, the carbon monoxide detector located in the boiler room is placed on the wall approximately 5 feet away from the gas burning boilers. Additionally, a the carbon monoxide detector located in the main laundry room is located approximately 10 feet away on the wall across from the gas burning dryer.

Plan of Correction **Accept**

Corrected during the time of inspection by the maintenance director. ON 2/9/21 inspector verified compliance with the regulation.

Completion Date: *02/09/2021*

Update - 03/01/2021

SP 03-01-2021 - Home will ensure carbon monoxide detectors are placed near fuel burning devices or appliances in accordance with Carbon Monoxide Alarms Standard Act.

Document Submission **Implemented**

Corrected during the time of inspection by the maintenance director. ON 2/9/21 inspector verified compliance with the regulation.

See attach picture of detectors 1 and 2

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

The criminal history background check for staff person A, who's first day of work was [redacted] was requested on 11/5/19. This is more than one year prior to the date of hire.

Plan of Correction **Accept**

All agency staff qualifications will be reviewed by the Executive Director or designee for compliance of regulation 2600.51. A updated criminal history check requested from the agency. ED or designee will monitor for compliance of the regulation monthly until 100% compliance of the regulation

Completion Date: *02/10/2021*

51 - Criminal Background Check *(continued)*

Document Submission **Implemented**

All agency staff qualifications will be reviewed by the Executive Director or designee for compliance of regulation 2600.51. A updated criminal history check requested from the agency. ED or designee will monitor for compliance of the regulation monthly until 100% compliance of the regulation

Criminal background was conducted on 12/30/20.. see POC Doc A

54a - Direct Care Staff

1. **Requirements**

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff persons A and B, do not have a high school diplomas, GED's, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction **Accept**

All agency staff qualifications reviewed for complaince of 2600.54a regualtion. Executive Director or designee will monitor for compliance of regulation monthly for 100% compliance and when new agency members begin at the community.

Completion Date: *02/10/2021*

Update - 03/01/2021

SP 03-01-21 - Home will ensure Staff members A and B meet qualifications of regulation for 2600.54a immediately. Documentation to be made available for Department review.

Document Submission **Implemented**

All agency staff qualifications reviewed for compliance of 2600.54a regulation. Executive Director or designee will monitor for compliance of regulation monthly for 100% compliance and when new agency members begin at the community.

See POC Doc A

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.

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

6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted] and Staff person B, 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.

Plan of Correction **Accept**

Executive Director or designee will orient all agency staff on 1st day in the community. Executive Director will review documentation of orientation quarterly for compliance of regulation

Completion Date: *02/12/2021*

Update - 03/01/2021

SP 03-01-2021 - Staff members A and B will receive general orientation in trainings specified in regulation 2600.65a immediately. Documentation to be made available for Department review

Document Submission **Implemented**

Executive Director or designee will orient all agency staff on 1st day in the community. Executive Director will review documentation of orientation quarterly for compliance of regulation
See POC Doc A

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

Staff person A and B completed their 40th scheduled work hour or or prior to 1/20/21. However, these staff persons 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**

Executive Director or designee will orient all agency staff in the community within 40 scheduled working hours on all training for 2600.65b regulation. Executive Director will review documentation of orientation quarterly for compliance of regulation

Completion Date: *02/12/2021*

65b - Rights/Abuse 40 Hours *(continued)*

Update - 03/01/2021

SP 03-01-2021 - Staff members A and B will receive general orientation in trainings specified in regulation 2600.65b immediately. Documentation to be made available for Department review

Document Submission **Implemented**

Executive Director or designee will orient all agency staff in the community within 40 scheduled working hours on all training for 2600.65b regulation. Executive Director will review documentation of orientation quarterly for compliance of regulation
See POC Doc A

65d - Initial Direct Care Training

1. **Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted] began providing unsupervised ADL services on 1/18/21. Direct care staff person B, hired on [redacted], began providing unsupervised ADL services on 12/6/20. However, the staff persons A and B did not complete and pass the Department approved direct care training course and pass the competency test prior to providing unsupervised ADL services.

Plan of Correction **Accept**

Executive Director or designee will monitor agency staff to comply with direct care training prior to unsupervised ADL's. . Executive Director will review documentation of orientation quarterly for compliance of regulation

Completion Date: *02/12/2021*

Update - 03/01/2021

SP 03-01-2021 - Staff members A and B will not provide unsupervised ADL services until they complete trainings specified in regulation 2600.65d. Documentation to be made available for Department review.

Document Submission **Implemented**

Executive Director or designee will monitor agency staff to comply with direct care training prior to unsupervised ADL's. . Executive Director will review documentation of orientation quarterly for compliance of regulation

See POC Doc A

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

On 2/8/21, a bottle of purple liquid hand soap, with a manufacture's label indicating "contact physician or poison control if swallowed " was unlocked, unattended, and accessible to residents in the housekeeping closet located in the kitchenette in the Bridges to Rediscovery Memory Care Unit. The closet was propped open with a mop bucket.

Plan of Correction **Accept**

Corrected during time of inspection by dietary; employee was cleaning up after breakfast. Employees in-service on poisonous materials on 2/8/21. Inspector reviewed in-service documentation of in-service on 2/9/21.
Executive Director or designee will monitor for compliance weekly until 100% compliance; staff will continue to in-service according to training plan

Completion Date: *02/09/2021*

Document Submission **Implemented**

Corrected during time of inspection by dietary; employee was cleaning up after breakfast. Employees in-service on poisonous materials on 2/8/21. Inspector reviewed in-service documentation of in-service on 2/9/21.
Executive Director or designee will monitor for compliance weekly until 100% compliance; staff will continue to in-service according to training plan

See POC DOC B

85a - Sanitary Conditions

1. **Requirements**

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

Description of Violation

On 2/9/2021 at approximately 11:00am, there was a a sticky dried brown substance present on the tray in the top drawer inside the Bridges to Rediscovery Medication cart.

Plan of Correction **Accept**

Director of Resident Care corrected during time of inspection; DRC will conduct med cart audits weekly x4 until 100% compliance of regulation. Med tech and nurses in-service on 2/10/21 by DRC on sanitation and medication storage.
Executive Director will conduct
random cart audits quarterly for compliance of the regulation

Completion Date: *02/10/2021*

Document Submission **Implemented**

Director of Resident Care corrected during time of inspection; DRC will conduct med cart audits weekly x4 until 100% compliance of regulation. Med tech and nurses in-service on 2/10/21 by DRC on sanitation and medication storage.
Executive Director will conduct
random cart audits quarterly for compliance of the regulation

See POC DOC C and D

100b - Removal Snow/Obstructions

1. **Requirements**

2600.

100b - Removal Snow/Obstructions *(continued)*

100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 2/8/21 at 10:30am, there was an approximate 3 inch accumulation of snow and ice present on the walkways outside of the emergency exits from the Rear Stair Tower, the Terrace exit doors, the Bryn Mawr stair tower doors, the conference lobby door #4. and the Bridges to Rediscovery Courtyard and gate walkway. The last snowfall for the area had ended approximately 24 hours prior to the inspection.

Plan of Correction **Accept**

Corrected during time of inspection by landscaping contractor; inspector reviewed area for compliance of the regulation on 2/9/21. ON 2/8/21 maintenance director in-service on maintaining clear paths around the community. Community purchased a snow blower to maintain outside community areas during inclement weather. Maintenance director and Executive Director will monitor for compliance during inclement weather.

Completion Date: *02/09/2021*

Document Submission **Implemented**

Corrected during time of inspection by landscaping contractor; inspector reviewed area for compliance of the regulation on 2/9/21. ON 2/8/21 maintenance director in-service on maintaining clear paths around the community. Community purchased a snow blower to maintain outside community areas during inclement weather. Maintenance director and Executive Director will monitor for compliance during inclement weather
See POC DOC E and pathway pictures

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 2/8/2021 at approximately 10:30 am, and accumulation of snow and ice blocked egress from the home's emergency exit doors in the Bryn Mawr Stair Tower. The emergency exit door could not be pushed outward to permit egress from the building. Additionally the walkways outside of the emergency exit doors at the Rear Stair Tower, the conference lobby door #4, and the courtyard outside of the Bridges to Rediscovery Memory Care Unit have not been cleared of snow and ice, creating obstructed egress from the home.

Plan of Correction **Accept**

Corrected during time of inspection by landscaping contractor; inspector reviewed area for compliance of the regulation on 2/9/21. ON 2/8/21 maintenance director in-service on maintaining clear paths around the community. Community purchased a snow blower to maintain outside community areas during inclement weather. Maintenance director and Executive Director will monitor for compliance during inclement weather.

Completion Date *02/09/2021*

121a - Unobstructed Egress *(continued)*

Document Submission **Implemented**

Corrected during time of inspection by landscaping contractor; inspector reviewed area for compliance of the regulation on 2/9/21. ON 2/8/21 maintenance director in service on maintaining clear paths around the community. Community purchased a snow blower to maintain outside community areas during inclement weather. Maintenance director and Executive Director will monitor for compliance during inclement weather

SEE POC Doc E and pictures

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

A bottle of Ketoconazole Shampoo with an expiration date of 10/2020 belonging to resident #2 was present on the medication cart. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction **Accept**

Director of Resident Care corrected during time of inspection; DRC will conduct med cart audits weekly x4 until 100% compliance of regulation. Med tech and nurses in service on 2/10/21 by DRC on medication storage. Executive Director will conduct
random cart audits quarterly for compliance of the regulation

Completion Date *02/10/2021*

Document Submission **Implemented**

Director of Resident Care corrected during time of inspection; DRC will conduct med cart audits weekly x4 until 100% compliance of regulation. Med tech and nurses in-service on 2/10/21 by DRC on medication storage. Executive Director will conduct
random cart audits quarterly for compliance of the regulation

See POC DOC C and D

184c - Sample Prescription Meds.

1. **Requirements**

2600.

184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

A loose package of Alendronate Sodium containing one table was present in the top drawer of the medication cart. The package was not labeled with a resident's name, or instructions for administration.

184c - Sample Prescription Meds. *(continued)*

Plan of Correction **Accept**

Director of Resident Care corrected during time of inspection; DRC will conduct med cart audits weekly x4 until 100% compliance of regulation. Med tech and nurses in service on 2/10/21 by DRC on medication storage and labeling .
Executive Director will conduct
random cart audits quarterly for compliance of the regulation

Completion Date *02/10/2021*

Document Submission **Implemented**

Director of Resident Care corrected during time of inspection; DRC will conduct med cart audits weekly x4 until 100% compliance of regulation. Med tech and nurses in-service on 2/10/21 by DRC on medication storage and labeling .
Executive Director will conduct
random cart audits quarterly for compliance of the regulation

185a - Implement Storage Procedures

1. **Requirements**

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3's glucometer has a reading of 120 on 2/9/21 at 7am, the corresponding recording written on the residents glucose log is 100.

Resident #4 is prescribed Famotidine 20mg take one by mouth every night as needed for heartburn. This medication is not present on the medication cart on 2/9/21.

On 2/9/21, the glucometer belonging to resident #4 was not calibrated to the correct date and time.

Plan of Correction **Accept**

Director of Resident care will conduct MAR audits weekly beginning 2/10/21 x 4 weeks for 100% compliance of regulation. Med techs and nurses was in-serviced on proper documentation and storage on 2/10/21. Executive Director will conduct random
random audits of MAR quarterly for compliance the regulation

Completion Date: *02/10/2021*

Document Submission **Implemented**

Director of Resident care will conduct MAR audits weekly beginning 2/10/21 x 4 weeks for 100% compliance of regulation. Med techs and nurses was in serviced on proper documentation and storage on 2/10/21. Executive Director will conduct random
random audits of MAR quarterly for compliance the regulation

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.

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

Description of Violation

Resident #4 is prescribed Ammonium Lactate Lotion 12%- apply every day. The resident medication administration record was initialed as administered for this medication on 2/9 however staff person C reported that medication was not available to give and that they incorrectly initialed the MAR.

Plan of Correction **Accept**

DRC will conduct MAR audits weekly beginning 2/10/21 x 4 weeks until 100% compliance of regulation. Medication technician and nurses in-service on proper administration and documentation 2/10/21. ED will conduct random audits of MAR quarterly for compliance of regulation

Completion Date: *02/10/2021*

Document Submission **Implemented**

DRC will conduct MAR audits weekly beginning 2/10/21 x 4 weeks until 100% compliance of regulation. Medication technician and nurses in-service on proper administration and documentation 2/10/21. ED will conduct random audits of MAR quarterly for compliance of regulation

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident #4 is prescribed Gabapentin 300mg one cap by mouth 3 times a day scheduled for 8am,1pm, and 5pm. This medication was not administered to resident #4 on 2/8 at 1pm.

Resident #4 is prescribed Humalog- inject 5 units at meal times scheduled for 8am, 12pm, 4pm. This medication was not administered to resident #4 on 2/4 at 12pm, or 2/5 at 4pm.

Resident #4 is prescribed Lantus- inject 28 units under the skin nightly at 5pm. This medication was not administered to resident #4 on 2/5 at 5pm.

Resident #4 is prescribed Ammonium Lactate Lotion 12% apply every day. This medication is not present on medication cart and was not administered to resident #4 on 2/5, 2/8 and 2/9.

Plan of Correction **Accept**

DRC will conduct MAR audits weekly beginning 2/10/21 x 4 weeks until 100% compliance of regulation. Medication technician and nurses in-service on proper administration and documentation 2/10/21. ED will conduct random audits of MAR quarterly for compliance of regulation

Completion Date: *02/10/2021*

Document Submission **Implemented**

DRC will conduct MAR audits weekly beginning 2/10/21 x 4 weeks until 100% compliance of regulation. Medication technician and nurses in-service on proper administration and documentation 2/10/21. ED will conduct random audits of MAR quarterly for compliance of regulation

231b - Medical Evaluation

1. **Requirements**

231b - Medical Evaluation *(continued)*

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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, the resident's medical evaluation was completed on 7/17/19.

Plan of Correction **Accept**

Occurred during prior administration; During the current administration, all medical evaluations are in compliance of 2600.231b regulation

Executive Director or designee will continue to review medical evaluations monthly for 100% compliance.

Completion Date: *02/09/2021*

Document Submission **Implemented**

Occurred during prior administration; During the current administration, all medical evaluations are in compliance of 2600.231b regulation

Executive Director or designee will continue to review medical evaluations monthly for 100% compliance

233c - Key-Locking Devices

1. **Requirements**

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism at the Bridges to Rediscovery conference lobby doors are not conspicuously posted near the doors.

Plan of Correction **Accept**

Corrected at the time of inspection. by BTR Director. Maintenance Director and/or ED will monitor for compliance of regulation during weekly rounds

Completion Date: *02/08/2021*

Document Submission **Implemented**

Corrected at the time of inspection. by BTR Director. Maintenance Director and/or ED will monitor for compliance of regulation during weekly rounds

See pictures of code

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.

234a - Admission Support Plan *(continued)*

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on 7/22/19.

Plan of Correction **Accept**

Occurred during prior administration; During the current administration, all support plans are in compliance of regulation

Executive Director or designee will continue to review medical evaluations monthly for 100% compliance.

Completion Date: *02/09/2021*

Document Submission **Implemented**

Occurred during prior administration; During the current administration, all support plans are in compliance of regulation

Executive Director or designee will continue to review medical evaluations monthly for 100% compliance