Department of Human Services
Bureau of Human Service Licensing

April 16, 2021

[redacted], ADMINISTRATOR
OLD ORCHARD HEALTH CARE CENTER - EASTON PA LLC
333 NORTH SUMMIT STREET
TOLEDO, OH 43604

RE: ARDEN COURTS OF OLD ORCHARD
4098 FREEMANSBURG AVENUE
EASTON, PA, 18045
LICENSE/COC#: 22604

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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,
Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *ARDEN COURTS OF OLD ORCHARD* **Licen e #**: *22604* **Licen e Expiration Date**: *01/17/2022*
Addre : *4098 FREEMANSBURG AVENUE, EASTON, PA 18045*
County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: *4843735135* **Email**: [redacted]

Legal Entity

Name: *OLD ORCHARD HEALTH CARE CENTER - EASTON PA LLC*
Address: *333 NORTH SUMMIT STREET, TOLEDO, OH, 43604*
Phone: *4843735135* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *10/15/2015* **Issued By**: *Bethlehem Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *30*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *64* **Residents Served**: *30*

Hospice

Current Re ident : *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *30*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

02/09/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *03/08/2021*

3/19/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/24/2021*

4/16/2021 - Document Submission

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

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

The required emergency numbers were not posted near the phone located in the studio wing's activity room.

Plan of Correction **Accept**

The Emergency Phone number list has been posted by the phone in the activity room, laminated and attached with zip tie (See attachment #1).

The activity staff will visibly check that the phone number list is posted by the phone, laminated and attached with zip tie, in the activity room on a daily basis and alert the Executive Director or designee if the list needs replaced immediately.

The coordinators and activity staff have been in-serviced regarding regulation 91 re. posting of emergency phone numbers and the need to communicate to the Executive Director or designee if the list needs replaced. (See attachment #2 & #12 in-service documentation). Executive Director or designee will ensure continued compliance.

Completion Date: *02/11/2021*

Update - 03/07/2021

Please submit proof of compliance.

Document Submission **Implemented**

Proof of compliance resubmitted again as an attachment

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

A package of frozen sausage links and a package of frozen sausage patties stored in clear plastic bags in the home's freezer were not dated or labeled with the name of the contents of the bags.

Plan of Correction **Accept**

The two (2) plastic bags of sausage patties were removed and disposed of immediately by the cook.

The Resident Services Supervisor or designee will conduct rounds twice per week to ensure all food is stored properly through 5/31/21. Audit tools will be available for survey review. (See attachment #3 RSS Daily Rounds)

The food service employees have been in-serviced on regulation103(e) on 2/11/21 by the Executive Director. (See attachment #4 in-service documentation). Executive Director will monitor for continued compliance.

Completion Date: *02/11/2021*

103e - Left Overs *(continued)*

Update - 03/07/2021

Please submit proof of compliance.

Document Submission **Implemented**

Proof of compliance resubmitted again as an attachment

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

Two loose pills were found at the bottom of the drawer in one of the home's medication carts.

Plan of Correction **Accept**

The two loose pills were immediately disposed of properly by the Resident Services Coordinator.

Weekly Medication Cart Audits are completed by the Resident Services Coordinator. Audit Tools will be available for survey review. (See attachment #5 RSS Daily Rounds)

The Resident Services Coordinator and Nursing Supervisors were in-serviced on Regulation 183(e) by the Executive Director. (See attachments #6 & #7 in-service documentation). Executive Director will continue to monitor for continued compliance through 5/31/21.

Completion Date: *02/11/2021*

Update - 03/07/2021

Please submit proof of compliance.

Document Submission **Implemented**

Proof of compliance resubmitted again as an attachment

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:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The Soliqua insulin pen belonging to resident #1 was stored in the medication cart in a clear plastic bag that did not have a pharmacy label attached to it.

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

Plan of Correction **Accept**

Name labels received from pharmacy, and attached to the insulin pen. (See attachment # 8)

Weekly medication cart audits are completed by the Resident Services Coordinator or designee and will continue through 5/31/21 (See attachment #9).

The nursing team was inserviced on Regulation 184a by Executive Director, and have comprehension for compliance. See Attachment #6).

Executive Director or designee to monitor to ensure continued compliance.

Completion Date: *02/11/2021*

Update - 03/07/2021

Please submit proof of compliance.

Document Submission **Implemented**

Proof of compliance resubmitted again as an attachment

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

The cognitive screening for resident #2 was completed 01/24/21. The resident was admitted to the home on [redacted]

The cognitive screening was completed more than 72 hours prior to the resident's admission to the home.

231c - Preadmission Screening *(continued)*

Plan of Correction **Accept**

The date of Section Two was questioned by the surveyor.

The surveyor read date the Cognitive Screening as being completed on 1/24/21,
n accordance to the regulation timeframe, the community upholds the Cognitive Screening was completed on [redacted]

This is based on the following:

Section One was completed on [redacted]*. Section Two was not completed prior to Section One; therefore, it was completed* [redacted] *and not 1/24/21.*

The Attachment was reviewed by the Regional Director of Operations and the Education Development Specialist on [redacted] *prior to the resident's admission. Both read the date as* [redacted]

During the survey, the Memory Care Advisor (who completed the Screening) verbalized to the surveyor that the date on the Screen is [redacted]

Move-In Documents are reviewed prior to move-in with audit tool. Audit tools will be available for survey review.

The Resident Services Coordinator and Administrative Services Coordinator were in-serviced on Regulation 231(c) by the Executive Director.
See attachment #10 in-service documentation)

The Executive Director will continue completion of the audit tool until May 30, 2021, and will continue to monitor for continued compliance.

Completion Date: *02/10/2021*

Update - 03/07/2021

Please submit proof of compliance.

Document Submission **Implemented**

Proof of compliance resubmitted again as an attachment

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 code posted outside all of the doors used to exit the secure dementia unit is *612. The actual code to operate the key pad is *216. The home did not have instructions posted on how to operate the key pad with regard to the posted code.*

233c - Key-Locking Devices *(continued)*

Plan of Correction **Accept**

The discussion sections reads: If a resident who has an identified need to be in a secured unit is able to follow written directions and obtain immediate egress from the
Home, the home may disguise the directions in a manner that permits staff persons and visitors to obtain immediate egress in an emergency.

The directions for the operations of all key-locking devices are posted conspicuously near the device.

The directions are in the form of a numerical code to disengage the key-locking device.

Residents have read the code and used it in an attempt to unlock the door, obtaining immediate egress from the Home.

Due to this ability, the codes are disguised in sequential order (as noted in the regulatory discussion section), which permits staff persons and visitors immediate egress in an emergency. (See attachment sample #11)

Staff persons are in-serviced on the operational directions during orientation (Building and Security Tour).

Visitors, i.e. family members are reviewed operational directions during community move-in tour.

The coordinators were in-serviced on Regulation 233(c) on 2/18/21 by the Executive Director. (See attachment #12)

Executive Director will monitor for continued compliance.

Completion Date: *02/18/2021*

Update - 03/07/2021

Please submit proof of compliance.

Document Submission **Implemented**

Proof of compliance resubmitted again as an attachment