

Department of Human Services
Bureau of Human Service Licensing

June 3, 2021

██████████ ADMINISTRATOR
FREDERICK MENNONITE COMMUNITY
2849 BIG ROAD - OFFICE
ZIEGLERVILLE, PA 19492

RE: FREDERICK LIVING - ASPEN VILLAGE
2849 BIG ROAD
ZIEGLERVILLE, PA, 19492
LICENSE/COC#: 13258

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/13/2021 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: *FREDERICK LIVING ASPEN VILLAGE* License #: 13258 License Expiration Date: 07/22/2021
Address: 2849 BIG ROAD, ZIEGLERVILLE, PA 19492
County: MONTGOMERY Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: 6107547878 Email: [REDACTED]

Legal Entity

Name: *FREDERICK MENNONITE COMMUNITY*
Address: 2849 BIG ROAD - OFFICE, ZIEGLERVILLE, PA, 19492
Phone: 6107547878 Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 11/13/2001 Issued By: Dept of L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 54 Waking Staff: 41

Inspection

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 05/13/2021

Inspection Dates and Department Representative

05/13/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 31 Residents Served: 27

Secured Dementia Care Unit

In Home: Yes Area: Aspen Capacity: 31 Residents Served: 27

Hospice

Current Residents: 1

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

05/13/2021 Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/31/2021

Inspections / Reviews (*continued*)

6/1/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow Up Type: *Document Submission*Follow-Up Date: *06/04/2021*

6/3/2021 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 5/13/21, the home did not have a copy of the current licensing inspection summary issued by the Department and a copy of this chapter (pink book) posted in a conspicuous and public place.

Plan of Correction**Accept**

What is the violation? At the time of the inspection, the home did not have the current licensing summary and a copy of the regulations were not in a public area.

Why did it occur? The violation occurred because the regulations, and the current inspection summary was in the care-base (nursing station), and this was not considered accessible.

What do we do right now to fix the problem?

Who: Administrator.

What: A signage was printed, and placed in a public area along with the other postings. The signage indicated that the inspection summary report, and the regulations are available in the care-base

When: This was done immediately while the inspector was on-site.

How do we prevent it from happening again?

Who: Administrator and Unit coordinator

What: A signage was printed, and placed in a public area immediately. Administrator and Coordinator will ensure that this along with the other required postings are maintained in the posting location at all times.

When: The signage indicating the availability of the current inspection summary and the regulations was placed immediately while the inspector was on-site.

Timeline/ work plan: what are the detailed steps needed to prevent it from happening again

Action taken/ owner/ completion date: This action was taken immediately to resolve the issue that was cited upon inspection.

Completion Date: 05/13/2021

3c - Post Current License (continued)

Document Submission

Implemented

What is the violation? At the time of the inspection, the home did not have the current licensing summary and a copy of the regulations were not in a public area.

Why did it occur? The violation occurred because the regulations, and the current inspection summary was in the care-base (nursing station), and this was not considered accessible.

What do we do right now to fix the problem?

Who: Administrator.

What: A signage was printed, and placed in a public area along with the other postings. The signage indicated that the inspection summary report, and the regulations are available in the care-base

When: This was done immediately while the inspector was on-site.

How do we prevent it from happening again?

Who: Administrator and Unit coordinator

What: A signage was printed, and placed in a public area immediately. Administrator and Coordinator will ensure that this along with the other required postings are maintained in the posting location at all times.

When: The signage indicating the availability of the current inspection summary and the regulations was placed immediately while the inspector was on-site.

Timeline/ work plan: what are the detailed steps needed to prevent it from happening again

Action taken/ owner/ completion date: This action was taken immediately to resolve the issue that was cited upon inspection.

101j5 - Bedside Table/Shelf

1. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 5. A bedside table or a shelf.

Description of Violation

On 5/13/21 at 9:40am, there is no bedside table next to resident #1's bed in bedroom [REDACTED].

101j5 - Bedside Table/Shelf (continued)

Plan of Correction

Accept

What is the violation? There was no bedside table next to Resident's bed in room [REDACTED]

Why did it occur? This occurred because upon moving into a semiprivate room, resident and [REDACTED] felt that resident would get more space if [REDACTED] used the bed side table as [REDACTED] tv stand.

What do we do right now to fix the problem? Spoke with resident to see if [REDACTED] would like facility staff to move the bedside table next to [REDACTED] bed, and placing a tv stand in the room.

Who: Coordinator

What: Resident was asked about moving the bedside table next to [REDACTED] bed and bringing in a tv stand for [REDACTED] television.

When: Resident was asked about moving the bedside table the following week.

How do we prevent it from happening again?

Who: Administrator/ Coordinator

What: When/If a resident prefers to utilize a piece of furniture for a different use such as in this instance, Coordinator will ensure that the resident's preference is documented in [REDACTED] plan of care / RASP.

When: This would be done immediately.

Timeline/ work plan: what are the detailed steps needed to prevent it from happening again

Action taken/ owner/ completion date: Administrator and Coordinator will ensure that if a resident prefers using a furniture or device differently due to choice, Coordinator will ensure that it is documented in the resident's RASP.

Completion Date: 05/28/2021

Document Submission

Implemented

What is the violation? There was no bedside table next to Resident's bed in room [REDACTED]

Why did it occur? This occurred because upon moving into a semiprivate room, resident and [REDACTED] felt that resident would get more space if [REDACTED] used the bed side table as [REDACTED] tv stand.

What do we do right now to fix the problem? Spoke with resident to see if [REDACTED] would like facility staff to move the bedside table next to [REDACTED] bed, and placing a tv stand in the room.

Who: Coordinator

What: Resident was asked about moving the bedside table next to [REDACTED] bed and bringing in a tv stand for [REDACTED] television.

When: Resident was asked about moving the bedside table the following week.

How do we prevent it from happening again?

Who: Administrator/ Coordinator

What: When/If a resident prefers to utilize a piece of furniture for a different use such as in this instance, Coordinator will ensure that the resident's preference is documented in [REDACTED] plan of care / RASP.

When: This would be done immediately.

Timeline/ work plan: what are the detailed steps needed to prevent it from happening again

Action taken/ owner/ completion date: Administrator and Coordinator will ensure that if a resident prefers using a furniture or device differently due to choice, Coordinator will ensure that it is documented in the resident's RASP.

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 #1 is prescribed Afluria Suspension (Influenza Virus Vaccine Split) Inject .5ml intramuscularly as needed for flu prevention. On 5/13/21 this medication was not available in the home.

Plan of Correction**Accept**

The order for the flu vaccine that was in point click care was discontinued.

when needed, An order will be obtained prior to administration, and discontinued after.

What is the violation? Resident #1 had an as needed order for flu vaccine, but the vaccine was not available within the unit.

Why did it occur? This occurred because the order for the flu vaccine was not discontinued in the documentation software (PCC).

What do we do right now to fix the problem?

Who: Clinical manager identified the issue immediately, and discontinued the order immediately.

What: The order for the flu vaccine was discontinued immediately from Resident #1 list of orders in Point clickcare.

When: This was done immediately on 5.13.21

How do we prevent it from happening again?

Who: Clinical manager/Unit nurse/ Med tech

What: Upon med audits, will ensure that there are no outstanding orders for residents. When a PRN order for a treatment or medication such as vaccine has been given, will ensure that the order is discontinued from PCC.

When: Order was discontinued immediately on 5.13.21. Documentation attached.

Timeline/ work plan: what are the detailed steps needed to prevent it from happening again

Action taken/ owner/ completion date: Orders for one time treatments such as vaccines will be imputed prior to administration, and discontinued after since vaccines are not typically stored within the unit. The unit nurse will ensure that this is completed.

Completion Date: 05/13/2021

185a - Implement Storage Procedures (*continued*)**Document Submission****Implemented**

The order for the flu vaccine that was in point click care was discontinued.

when needed, An order will be obtained prior to administration, and discontinued after.

What is the violation? Resident #1 had an as needed order for flu vaccine, but the vaccine was not available within the unit.

Why did it occur? This occurred because the order for the flu vaccine was not discontinued in the documentation software (PCC).

What do we do right now to fix the problem?

Who: Clinical manager identified the issue immediately, and discontinued the order immediately.

What: The order for the flu vaccine was discontinued immediately from Resident #1 list of orders in Point clickcare.

When: This was done immediately on 5.13.21

How do we prevent it from happening again?

Who: Clinical manager/Unit nurse/ Med tech

What: Upon med audits, will ensure that there are no outstanding orders for residents. When a PRN order for a treatment or medication such as vaccine has been given, will ensure that the order is discontinued from PCC.

When: Order was discontinued immediately on 5.13.21. Documentation attached.

Timeline/ work plan: what are the detailed steps needed to prevent it from happening again

Action taken/ owner/ completion date: Orders for one time treatments such as vaccines will be imputed prior to administration, and discontinued after since vaccines are not typically stored within the unit. The unit nurse will ensure that this is completed.