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

July 12, 2021

[redacted] EXECUTIVE DIRECTOR
NORTH WALES 1089 MC BG OPCO LLC
330 N WABASH AVENUE,SUITE 3700
CHICAGO, IL 60611

RE: PARK CREEK PLACE - MEMORY CARE
1089 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14256

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/20/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Mia Johnson

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

# Department of Human Services
# Bureau of Human Service Licensing
# LICENSING INSPECTION SUMMARY - PUBLIC

## Facility Information

**Name**: *PARK CREEK PLACE MEMORY CARE* **Licen e #**: *14256* **Licen e Expiration Date**: *10/02/2021*
**Addre** : *1089 HORSHAM ROAD, NORTH WALES, PA 19454*
**County**: *MONTGOMERY* **Region**: *SOUTHEAST*

## Administrator

**Name**: [redacted] **Phone**: *2155400520* **Email**: [redacted]

## Legal Entity

**Name**: *NORTH WALES 1089 MC BG OPCO LLC*
**Address**: *330 N WABASH AVENUE,SUITE 3700, CHICAGO, IL, 60611*
**Phone**: *2155400520* **Email**: [redacted]

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *07/19/1996* **Issued By**: *L&I*

## Staffing Hours

**Re ident Support Staff**: *0* **Total Daily Staff**: *50* **Waking Staff**: *38*

## Inspection

**Type**: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
**Reason**: *Incident* **Exit Conference Date**: *05/20/2021*

## Inspection Dates and Department Representative

*05/20/2021 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *48* **Residents Served**: *25*

### Secured Dementia Care Unit

**In Home**: *No* **Area**: **Capacity**: **Residents Served**:

### Hospice

**Current Residents**: *6*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *25*
**Diagnosed with Mental Illness**: *0* **Diagnosed with Intellectual Disability**: *0*
**Have Mobility Need**: *25* **Have Physical Disability**: *0*

## Inspections / Reviews

**05/20/2021 Partial**

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/21/2021*

## Inspections / Reviews *(continued)*

**7/1/2021 - POC Submission**

**Lead Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow-Up Date:** *07/04/2021*

**7/12/2021 Document Submi ion**

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

## 23a - Activities of Daily Living Assistance

**1. Requirements**

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

**Description of Violation**

*The assessment and support plan, dated 4/16/21, for resident 1 indicates the resident requires two person assistance with transferring. On 4/21/21, the resident did not receive this assistance as required. Staff person A transferred resident 1 from [redacted] bed to [redacted] wheelchair.*

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

*• Resident #1 did not suffer a negative effect related to this finding.*

*• Staff Person A is no longer employed by the community.*

*• On 06/16/2021 the Care Services Manager (CSM) in-serviced direct care staff on the requirements stated within 2600.23.a. (Exhibit A- In- Service sign in sheet)*

*• On 06/16/2021 the CSM validated the accuracy of current residents Resident Assessment and Support Plan (RASP), section titled "Transferring in/out of bed/chair" ensuring transfer assistance needs are reflected on staff communication task sheets. (Exhibit B- Audit tool)*

*• The CSM and/or designee will audit by observation five random staff assisted resident transfers weekly x 4 weeks, then bi-weekly x 2 weeks, then monthly x 1, to ensure each resident received assistance as indicated and required of their RASP. (Exhibit C- Audit Tool)*

*• Results of the audit will be discussed during Monthly Quality Improvement (QI) meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.*

**Completion Date:** *06/16/2021*

**Document Submission** **Implemented**

*See Attached*

## 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**

*Staff person A, whose first day of work was [redacted] did not receive orientation on the following topics: evacuation procedures.*

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

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

*• On date of hire, [redacted], Staff Person A completed all training topics in accordance with 2600.265(a). Staff Person A mistakenly omitted their signature and date in section titled "Evacuation procedures" of their training file.*
*• Staff Person A is no longer employed by the community.*
*• On 06/15/2021, the ED completed an audit of current employee files, validating compliance as per 2600.265(a). Exhibit D- Audit Tool)*
*• On 06/15/2021, the ED in-serviced the Administrative Specialist on the requirements stated within 2600.265.a.*
*• Beginning 6/11/2021, for the duration of 90 days, the Executive Director and/or designee will audit newly hired employee personnel files on an employees first day of employment to validate that their signatures, with corresponding dates, are present in each section of their file in relation to the required orientation topics numbers 1 through 7, as stated within 2600.265.a. (Exhibit E- Audit Tool)*
*• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.*

**Completion Date:** *06/15/2021*

**Document Submission** **Implemented**

*See Attached*

## 201 - Positive Interventions

1. **Requirements**

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

**Description of Violation**

*Resident 1, started yelling and cursing and tried to bite staff person A when [redacted] attempted to bath [redacted]. The home has not implemented positive interventions to modify or eliminate the behavior. On 4/21/21, staff person A held the residents hands together close to [redacted] neck area while [redacted] washed [redacted] face.*

## 201 - Positive Interventions *(continued)*

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

*• Resident #1 did not suffer a negative effect from this finding.*
*• On [redacted] Staff Person A was placed on administrative leave pending the outcome of the investigation.*
*• On [redacted] Pennsylvania Department of Human Services permitted Staff Member A to return to duty without restrictions pending the completion of an in-service training on safe management techniques.*
*• Staff Member A resigned from position on [redacted].*
*• By 07/01/2021, the CSM and or designee will audit current residents RASPs to ensure the presence of positive redirection and de-escalation techniques for residents who exhibit behaviors. (Exhibit F- Audit Tool)*
*• On 06/16/2021, the ED and CSM in-serviced direct care staff on the requirements stated within 2600.201 and on "Resident Handling - Safe Management Techniques". (Exhibit G- In-Service Training)*
*• The CSM and/or designee will audit by observation of five random staff-to-resident interactions weekly x 4 weeks, then bi-weekly x 2 weeks, then monthly x 1, to validate that staff implement safe management techniques. (Exhibit H- Audit Tool)*
*• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.*

**Completion Date:** *06/16/2021*

**Document Submission** **Implemented**

*See Attached*

## 202 - Prohibitions

1. **Requirements**

2600.

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

**Description of Violation**

*On 4/21/21 at approximately 6:30 am, resident 1's hands were held together near [redacted] face and neck area. Staff person A used [redacted] hands to manually restrain resident 1 by holding [redacted] hands together.*

## 202 - Prohibitions *(continued)*

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

*• Resident #1 did not suffer a negative effect from this finding.*
*• On [redacted], Staff Person A was placed on administrative leave pending the outcome of the investigation.*
*• On [redacted], Pennsylvania Department of Human Services permitted Staff Member A to return to duty without restrictions pending the completion of in-service training on safe management techniques. Staff Member A resigned from position on [redacted].*
*• On 06/16/2021, the ED and CSM in-serviced direct care staff on the requirements stated within 2600.202 and on "Resident Handling - Safe Management Techniques". (Exhibit G- In-Service Training)*
*• By 07/01/2021, the CSM and or designee will audit current residents RASPs to ensure the presence of positive redirection and de-escalation techniques for residents who exhibit behaviors. (Exhibit F- Audit Tool)*
*• The CSM and/or designee will audit by observation five random staff-to-resident interactions weekly x 4 weeks, then bi-weekly x 2 weeks, then monthly x 1, to validate that staff implement safe management techniques. (Exhibit H- Audit Tool)*
*• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.*

**Completion Date:** *06/16/2021*

**Document Submission** **Implemented**

*See Attached*