Department of Human Services
Bureau of Human Service Licensing

July 30, 2021

SHP V WILLISTOWN LLC
3715 NORTHSIDE PKWAY NW 300-110
ATLANTA, GA 30327

RE: ARBOR TERRACE WILLISTOWN
1713 WEST CHESTER PIKE
WEST CHESTER, PA, 19382
LICENSE/COC#: 14245

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/30/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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: *ARBOR TERRACE WILLISTOWN* **License #**: *14245* **License Expiration Date**: *07/19/2021*
Address: *1713 WEST CHESTER PIKE, WEST CHESTER, PA 19382*
County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *6107251713* **Email**: [redacted]

Legal Entity

Name: *SHP V WILLISTOWN LLC*
Address: *3715 NORTHSIDE PKWAY NW 300-110, ATLANTA, GA, 30327*
Phone: *6107251713* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/29/2013* **Issued By**: *Willistown Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *119* **Waking Staff**: *89*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *06/30/2021*

Inspection Dates and Department Representative

06/30/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Evergreen- 1st Floor* **Capacity**: *35* **Residents Served**: *27*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *46* **Have Physical Disability**: *0*

Inspections / Reviews

06/30/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/19/2021*

7/29/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/02/2021*

7/30/2021 - Document Submission

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

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.

Description of Violation

A bottle of Medichoice roll on antiperspirant, with a manufacture's label indicating "if swallowed, get medical help or contact a poison control immediately", was unlocked, unattended, and accessible in resident #1's bedroom. Not all the residents of the home, including resident #1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction **Accept**

Upon discovery that the bottle of antiperspirant was unlocked in Resident #1's room, it was corrected immediately at the time of inspection by being locked up. A re-training on this regulation was completed with the Memory Care Director, along with all memory care staff, on 7/1/21 (please see attached Exhibit A). Additionally, a form was created (please see attached Exhibit B) to document and track weekly chemical checks on all memory care apartments, which will be completed by the Memory Care Director or designee for the next 90 days. Compliance with regulation 2600.82(c) is the responsibility of the Administrator, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(please see attached Exhibit A) (please see attached Exhibit B)

85a - Sanitary Conditions

1. **Requirements**

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

Description of Violation

On 6/30/21, a used, soiled, balled up tissue was observed in 3rd drawer of the Evergreen Medication Cart.

Plan of Correction **Accept**

Upon discovery that a used tissue was in the Evergreen Medication Cart, the tissue was disposed of immediately at the time of the inspection and the cart was disinfected for sanitation. Maintaining sanitary conditions is a team effort; therefore, a re-training was completed (please see Exhibit C) with all staff on 7/1/21 on regulation 2600.85(a). Additionally, weekly medication cart audits (please see attached Exhibit D) will be completed by the Resident Care Director or designee for compliance with storage, cleanliness, organization and safety for the next 90 days. Compliance with regulation 2600.85(a) is the responsibility of the Administrator, Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(Please see attached Exhibit C) (Please see attached Exhibit D)

101j7 - Lighting/Operable Lamp

1. **Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

Resident #2 and #3, who share a bedroom, do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction **Accept**

Upon discovery that Resident #2 and #3 did not have a lamp or other source of lighting that could be turned on at bedside, a lamp was immediately added to correct the finding. Additionally, since the housekeeping go into every apartment to provide a weekly service, these staff members were re-trained (please see attached Exhibit E) on this regulation, and that they are to report to the Maintenance Director or Executive Director if an apartment does not have a light source operable at bedside so one can be added immediately. Compliance with regulation 2600.101(j)(7) is the responsibility of the Administrator, Maintenance Director, or designee.

Completion Date: *07/14/2021*

Document Submission **Implemented**

(Please see attached Exhibit E)

105g - Lint Removal and Duct Cleaning

1. **Requirements**

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 6/30/21, there was an approximate ¼" accumulation of lint in lint trap. There are also lint traps accessible in the duct work above and behind the dryers. The duct lint traps are designed to be cleaned out after every use according to the maintenance manager. There is an approximate ½" accumulation of lint in the duct traps. There were no clothes in the dryer at the time.

Plan of Correction **Accept**

Upon discovery of the lint accumulation in the dryer lint trap, the lint was corrected immediately at the time of inspection. Additionally, all other dryers were checked for lint at the time of inspection with no additional findings of accumulation. A re-training was completed on 7/14/21 (please see attached Exhibit F) with all Resident Assistants that it is [redacted] responsibility to clean the trap of lint after every use. Additionally, a training was completed on 7/14/21 with each Med Tech that it is his/her responsibility to check the lint traps for accumulation once per shift as an additional added measure for compliance. Moreover, the lint traps that were external behind the dryers were removed by the Maintenance Director to minimize unnecessary lint accumulation. Also, all dryer vents are serviced by a 3rd party provider on a semi-annual basis. Compliance with regulation 2600.107(d) is the responsibility of the Administrator, Resident Care Director, Maintenance Director, or designee.

Completion Date: *07/14/2021*

Document Submission **Implemented**

(Please see attached Exhibit F)

107d - Procedure Emergency Management Agency Submission

1. **Requirements**

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

107d - Procedure Emergency Management Agency Submission *(continued)*

Description of Violation

The home's written emergency procedures have not been sent to the local emergency management agency. The home did send a notice to the local emergency management agency in 2019 however the actual emergency procedures were not sent along with the letter.

Plan of Correction — **Accept**

Upon discovery that the 2020 letter was not submitted by the previous Administrator, and upon discovery that the 2021 letter submission did not show evidence that a copy of the emergency procedure plan was included in that submission, an updated letter (please see attached Exhibit G) was submitted on 7/1/21 to the local emergency management agency to correct the issue immediately. Compliance with regulation 2600.107(d) is the responsibility of the Administrator or designee.

Completion Date: *07/01/2021*

Document Submission — **Implemented**

(Please see attached Exhibit G)

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

On 6/30/21, 1 small round blue tablet was observed loose in the 3rd drawer of 2nd Floor Medication Cart.

Plan of Correction — **Accept**

Upon discovery that a small blue tablet was loose in the 3rd drawer of the 2nd Floor Medication Cart, it was removed and disposed of immediately. An audit of all other Medication Carts was completed immediately during the inspection by the Resident Care Director resulting in no new findings. Moreover, weekly audits of all Medication Carts will be completed by the Resident Care Director or designee (please see attached Exhibit D). Compliance with regulation 2600.183(e) is the responsibility of the Resident Care Director or designee.

Completion Date: *07/31/2021*

Document Submission — **Implemented**

(Please see attached Exhibit D)

184b - Resident's Meds Labeled

1. **Requirements**

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 6/30/21, a package of Famotidine 20mg tablets was in the bottom drawer of Evergreen Memory Care medication cart and was not labeled with a resident's name.

184b - Resident's Meds Labeled *(continued)*

Plan of Correction **Accept**

A new resident moved in to the community on 6/29/21 with an order for Famotidine 20mg tablets and this medication was secured in the Medication Cart; however, the name of the resident had not yet been recorded on the package at the time of inspection on 6/30/21. Upon discovery of the issue, the package was immediately labeled by the Memory Care Director with the resident's name. A re-training was completed on 7/1/21 (please see attached Exhibit H) with the Resident Care Director and Memory Care Director to ensure that all OTC and CAM are reviewed at the time of move-in to prevent future occurrences. Compliance with regulation 2600.184(b) is the responsibility of the Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(Please see attached Exhibit H)

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 #4 has an order for glucose checks to be completed once a day, scheduled for 8am.
The following readings recorded on the glucose log do not match the corresponding meter readings:

- *6/23/21 135 recorded on the log at 8:00am- meter reading of 139 at 7:37am*
- *6/12/21 79 recorded on the log at 8:00am- meter reading of 108 at 7:46am*

Resident 5 has an order to have glucose checks completed twice a day. On 6/28/21 at 9pm there is a reading of 208 recorded on the glucose log, however there is no corresponding reading in the meter for that date and time.

Resident #6 has an order for accuchecks to be completed before meals, scheduled for 8am, 11am, and 4pm. On the following dates, there is a reading recorded on the glucose log however there is no corresponding reading in the residents glucometer.

- *6/26/21 at 8am- 146 recorded on log- there is no reading in the meter*
- *6/19/21 at 4pm- 171 recorded on log- there is no reading in the meter*
- *6/18/21 at 4pm- 180 recorded on log- there is no reading in the meter*
- *6/17/21 at 4pm- 147 recorded on log- there is no reading in the meter*

Additionally , for Resident #6, on 6/29/21 at 8am there is a recorded reading of 139 on the glucose log, however the corresponding meter reading is 135.

Resident #6 has an order for Bacitracin Ointment- cleanse right foot big toe w/nss, apply bacitracin and cover with a Band-Aid as needed. This medication is not present in the medication cart on 6/30/21

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

Upon discovery of the issue, our Resident Care Director, who is a Certified Diabetic Trainer, scheduled a retraining with all Diabetic Certified Staff on Diabetic Management Procedures to be completed on or before 7/31/21. To prevent future occurrences, the 11pm-7am shift supervisor will complete a review of the previous day's glucose monitoring for the next 90 days. Additionally, it was identified that Resident #6 had an active order for Bacitracin Ointment to be applied to a wound on his right foot, but the medication was not present on the Medication Cart at the time of inspection. The Memory Care Director investigated and determined that the wound had healed and the medication had been disposed of because there was no longer a need, but the Memory Care Director or designated medication provider had no contacted the physician to request an updated order to discontinue the medication. Upon learning this information, the discontinue order for the Bacitracin Ointment was requested by the physician and received on 7/2/21 (please see attached Exhibit I). Compliance with regulation 2600.185(a) is the responsibility of the Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/31/2021*

Document Submission **Implemented**

(Please see attached Exhibit I)

225a - Assessment 15 Days

1. **Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident #7, who was admitted to the home on [redacted].

Plan of Correction **Accept**

It was discovered that Resident #7 did not have a written initial assessment documented upon move-in on [redacted] (please note that on the violation report we received, it lists the resident's move-in date in error as [redacted]). The Memory Care Director who was responsible for the initial assessment is no longer employed by the Home. Upon the discovery of this issue, an audit was completed by the current Memory Care Director to determined if any other residents did not have an initial assessment documented, but there were no new findings from that audit. Audits of all charts, prior to move-in for new residents, are completed by the Resident Care Director or Memory Care Director utilizing the Move-In Checklist (please see attached Exhibit K). Compliance with regulation 2600.225(a) is the responsibility of the Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(Please see attached Exhibit K)

225c - Additional Assessment

1. **Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

225c - Additional Assessment *(continued)*

Description of Violation

Resident #7's current assessment found in the residents file is undated. It is marked as residents annual assessment with a note stating that residents initial RASP cannot be located. It is unclear when this annual assessment was actually completed.

Plan of Correction **Accept**

It had previously been identified on 3/8/21 by our new Memory Care Director that the initial RASP for Resident #7 that was not completed by the previous Memory Care Director was missing. The current Memory Care Director documented ██ findings on the new RASP that the previous initial RASP could not be located when ██ developed the updated RASP. This updated RASP was signed by the Memory Care Director on 3/8/21; however, the updated RASP does not indicate the date that the updated assessment was completed on. Upon discovery of this finding, an updated RASP was completed by the Memory Care Director on 7/1/21 (please see attached Exhibit J). An audit was completed by the Resident Care Director and Memory Care Director of all other resident charts with no additional new findings. Compliance with regulation 2600.225(c) is the responsibility of the Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(Please see attached Exhibit J)

227g -Support Plan Signatures

1. **Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #8's support plan dated ██████, is not signed by the assessor or the resident, or anyone else who participated in the development of the support plan.

Plan of Correction **Accept**

Upon discovery that Resident #8's support plan dated ██████ was not signed by the assessor or the resident, an updated assessment and support plan was created for Resident #8 on █████ and the assessment was signed by both Resident #8 as well as the assessor, our Memory Care Director (please see attached Exhibit L). An audit was completed by the Resident Care Director and Memory Care Director of all other resident charts with no new findings For all new residents, the Move-In Checklist (please see attached Exhibit J) will be utilized to ensure all support plans are signed and dated upon move-in. Compliance with regulation 2600.231(f) is the responsibility of the Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(please see attached Exhibits L and J)

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.

231c - Preadmission Screening *(continued)*

Description of Violation

Resident #6 was admitted to the Secure Dementia Care Unit (SDCU) on . However, resident #6's written cognitive preadmission screening was completed on , this is outside of the 72 hour timeframe.

Resident #8 was admitted to the Secure Dementia Care Unit (SDCU) on 1 . However, a cognitive preadmission screening was not completed prior to admission.

Plan of Correction **Accept**

It was discovered that Resident #8 did not have a pre-admission screening complete when transferred to the secure dementia care unit on ; however, a cognitive pre-admission screening was not completed by the previous Memory Care Director when the transfer took place. Upon news of this finding, an updated cognitive pre-admission screening was completed by the Administrator on please see attached Exhibit M). An audit of all resident charts that reside within our secure dementia care unit was completed on by the Memory Care Director with no new findings of any cognitive pre-admission screenings missing or out of compliance. Additionally, a re-training was completed (please see attached Exhibit N) with the Memory Care Director on 7/1/21 on this regulation's requirements. Compliance with regulation 2600.231(c) is the responsibility of the Administrator, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(Please see attached Exhibit N)

231f - Assessed Annually

1. **Requirements**

2600.

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident #7 was assessed for the need for Secure Dementia Care Unit (SDCU) on and was not assessed again.

Plan of Correction **Accept**

It was discovered that Resident #7's Documentation of Medication Evaluation assessing Resident #7's need for a secure dementia care unit was completed on ; however, the annually updated assessment was not completed for 2021. Upon discovery of this issue, an updated assessment was completed on documenting Resident #7's continuing need for the secure dementia care unit (please see attached Exhibit O). Additionally, an audit of all resident charts was completed by the Memory Care Director on 7/1/21 with no new findings. Moreover, to prevent future occurrences, a tracker system (please see attached Exhibit P) was created for all Memory Care residents, similar to the tracker already being utilized in Personal Care, as to when annual assessments are due to be updated. Compliance with regulation 2600.231(f) is the responsibility of the Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(Please see attached Exhibit O and P)

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

On 6/30/21, The directions for operating the home's locking mechanism are not conspicuously posted near the exit door in the Namaste living room area in the Secure Dementia Care Unit (SDCU).

Plan of Correction **Accept**

Upon discovery that one of the directions for operating the locking mechanism of an exit door in the Namaste living room area of the Secure Dementia Care Unit was not posted, the code was posted immediately (please see attached Exhibit Q). The Administrator and Maintenance Director immediately checked all other exits to verify that the codes were posted conspicuously near each exit and there were no other doors missing the code posting. Compliance with regulation 2600.233(c) is the responsibility of the Administrator, Maintenance Director, or designee.

Completion Date: *06/30/2021*

Document Submission **Implemented**

(Please see attached Exhibit Q)

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 #7 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was not completed.

Resident #8 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was not completed.

Plan of Correction **Accept**

It had previously been identified on 3/8/21 by our new Memory Care Director, that the initial RASP for Resident #7 that was completed by the previous Memory Care Director was missing. When it was discovered on 3/8/21 an initial RASP for Resident #7 was completed immediately, although it was missing the date as previously discussed above in reference to the plan of correction for regulation 2600.225(c), so an additional RASP was completed for Resident #7 on [redacted]. Additionally, it was discovered that Resident #8's initial RASP was not completed, so on [redacted] an updated RASP was completed as shown in evidence for plan of correction for regulation 2600.225(c). An audit was completed by the Resident Care Director and Memory Care Director of all other resident charts with no additional findings out of compliance. Compliance with regulation 2600.234(a) is the responsibility of the Resident Care Director, Memory Care Director, or designee.

Completion Date: *07/01/2021*

Document Submission **Implemented**

(Please see attached Exhibit J)