Department of Human Services
Bureau of Human Service Licensing

September 30, 2021

[redacted], ADMINISTRATOR
[redacted]

RE: ARDEN COURTS OF KING OF PRUSSIA
620 WEST VALLEY FORGE ROAD
KING OF PRUSSIA, PA, 19406
LICENSE/COC#: 12995

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/13/2021, 07/15/2021, 07/16/2021, 07/26/2021, 07/27/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

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: *ARDEN COURTS OF KING OF PRUSSIA* **License #:** *12995* **License Expiration Date:** *12/29/2021*
Address: *620 WEST VALLEY FORGE ROAD, KING OF PRUSSIA, PA 19406*
County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *08/10/1995* **Issued By:** *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *84* **Waking Staff:** *63*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *07/27/2021*

Inspection Dates and Department Representative

07/13/2021 - On-Site: [redacted]
07/15/2021 - Off-Site: [redacted]
07/16/2021 - Off-Site: [redacted]
07/26/2021 - Off-Site: [redacted]
07/27/2021 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served:** *42*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Memory Care Community* **Capacity:** *64* **Residents Served:** *42*

Hospice

Current Residents: *7*

Resident Demographic Data as of Inspection Dates *(continued)*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *42*
Diagnosed with Mental Illness: *4*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *42*
Have Physical Disability: *0*

Inspections / Reviews

07/13/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/12/2021*

9/15/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/18/2021*

9/30/2021 - Document Submission

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

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], resident #1 eloped from the home and sustained a skin tear to [redacted] hand from climbing over the fence of the home. The home did not report this incident to the department until [redacted].

On [redacted], resident #1 died in the home. The home did not report this incident to the department.

Plan of Correction **Accept**

The coordinators and nursing supervisors were in-serviced by the Executive Director regarding regulation 16.c. on 9/8/21 and 9/9/21 of the need to report incidents and conditions to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. (See attachment – In-service documentation and collateral)

Reportable Incidents will be reviewed daily in the Stand-Up Minutes. Dates - 9/15/21 through 12/15/21. The Stand-Up Minutes and Reportable Incident and Condition Trending log will be updated accordingly and will be available for survey review. (See attachment – Stand-Up Minute and The Reportable Incident and Condition Log).

Completion Date: *09/12/2021*

Document Submission **Implemented**

NA

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 7/13/21, at 9:53 am, the resident summary sheet for resident #2 was left unattended and accessible in the kitchenette located in Clover Dale. The summary sheet contained confidential information in reference to medical concerns and power of attorney contact information.

17 - Record Confidentiality *(continued)*

Plan of Correction **Accept**

The summary sheet for resident #2 was immediately placed in laundry room communication board (an area that meets the Record Confidentiality criteria re. regulation 17). (See attachment of photo – location of summary sheet).
Staff was in-serviced by the Executive Director on 9/8/21 and 9/9/21 regarding regulation 17 (record confidentiality). (See attachment In-service documentation and collateral)
The Executive Director or designee will complete daily rounds that includes compliance with regulation 17. Dates - 9/15/21 through 12/15/21. Any non-compliance with record confidentiality will be addressed immediately and documented in the Stand-Up Minutes. The Stand-Up Minutes will be available for survey review.
(See attachment – Stand-Up Minutes)

Completion Date: *09/12/2021*

Document Submission **Implemented**

NA

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1 admitted to the secured unit on [redacted] with known tendencies of eloping. On [redacted], resident #1 was able to exit the home, climb over an 8-foot fence; while staff person A, watched [redacted] behavior. Resident #1, then crossed the driveway of the secured unit and reached the property of a neighbor's home and started to bang on the door in distress. Staff persons B and C failed to utilize verbal techniques as mentioned in the support plan to assist with [redacted] safe return into the home. Staff persons B and C carried resident #1 off the neighboring property in a horizontal method. Staff person B held the resident under [redacted] arms while staff person C held [redacted] legs and carried [redacted] back to [redacted] room. The resident sustained a skin tear on [redacted] left hand below [redacted] thumb.

42b - Abuse *(continued)*

Plan of Correction **Accept**

Resident #1 was immediately treated for [redacted] skin abrasion, vital signs obtained, placed on 15 minute checks, physician and wife notified. (See attachments)
Staff Member A, B & C were in-serviced by Executive Director on 9/10/2021 on Behavior Management. (See attachment in-service documentation and collateral)
A resident with tendencies to eloping behaviors will have those behaviors and appropriate interventions placed on their support plan. The support plan will be available for staff review. Resident support plans will be available for survey review.
Staff will be in-serviced by the Executive Director on 9/14/21 and 9/16/2021 regarding regulation 42.b., appropriate verbal approaches, and Safe Management Techniques.
In-Service Documentation will be forwarded after completion. (See attachment – collateral)
Staff will be in-serviced by the Executive Director on a monthly basis (September – December) on regulation 42.b., appropriate verbal approaches and Safe Management Techniques. In-service records will be available for survey review.

Completion Date: *09/12/2021*

Document Submission **Implemented**

Please find collateral and in-service documentation for in-service on 9/14/21 & 9/16/21.

85a - Sanitary Conditions

1. **Requirements**

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

Description of Violation

On 7/13/21, at 9:57 am, the trash can in the spa room located in Clover Dale contained soiled personal products creating a malodorous smell in the bathroom.

Plan of Correction **Accept**

The trash can in the spa room located in Clover Dale was emptied immediately of soiled personal products.
Staff was in-serviced by the Executive Director on 9/8/21 and 9/9/21 regarding regulation 85.a. – sanitary conditions, including soiled personal products in a trash can. (See attachment - In-service documentation and collateral)
The Building Services Coordinator or designee will complete daily rounds to ensure compliance with regulation 85.a. regarding sanitary conditions. Dates – 9/15/21 through 12/15/21. Rounds will be available for survey review. (See attachment – Monthly Daily Rounds - Building Cleanliness).

Completion Date: *09/12/2021*

Document Submission **Implemented**

NA

103f - Refrigerator/Freezer Temps

1. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the refrigerator located in the kitchenette area referenced as Clover Dale.

Plan of Correction **Accept**

A thermometer was immediately placed in the refrigerator located in the kitchenette – Clover Dale.
Temperature checks for all refrigerators in all units will be completed by the Food Services Coordinator or designee and documented on the Temperature Log for that house/unit. Dates -9/15/21 through 12/15/21. The Temperature Log will be available for survey review.
(See attachment - Temperature Log)
The Food Services Coordinator, food service staff, and coordinators were in-serviced by the Executive Director on 9/8/21 and 9/9/21 regarding regulation 103.f. and the Temperature Log. (See attachment – In-service documentation and collateral)

Completion Date: *09/12/2021*

Document Submission **Implemented**

NA

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.

Description of Violation

Resident #3 is prescribed [redacted] *and* [redacted] *Resident #3's July 2021 medication administration record does not include the initials of the staff person who administered* [redacted] *tablet,* [redacted] *tablet,* [redacted] *and* [redacted] *tablet on 7/11/21 at 8:00 pm.*

Plan of Correction **Accept**

Staff whose initials were missing was counseled. (See attachment)
Medication cart audits will be conducted by the Resident Services Coordinator or a designee on a weekly basis to ensure compliance with regulation 187.b. Dates – 9/15/21 through 12/15/21. Any non-compliance will be addressed immediately. The audits will be available for survey review. (See attachment - blank Med Cart Audit form – MOR reviewed for completeness)
The Coordinators, Resident Services Supervisors and Medication Technicians were in-serviced on 9/8/21 and 9/9/21 by the Executive Director regarding regulation 187.b. – the requirement that information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. (See attachment – In-service documentation and collateral)

Completion Date: *09/12/2021*

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

Document Submission **Implemented**

NA

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, eloped from the home and entered a neighboring property. The home has not implemented positive interventions to modify or eliminate the behavior. On 3/6/21, staff persons B and C failed to utilize positive interventions while assisting resident #1 back into the home. Staff persons B and C, lifted the resident off [redacted] feet by holding [redacted] up under [redacted] arms and [redacted] feet and carried [redacted] into the building.

Plan of Correction **Accept**

Resident #1 was immediately treated for [redacted] skin abrasion, vital signs obtained, placed on 15 minute checks, physician and wife notified. (See attachments)

Staff Member A, B & C were in-serviced by Executive Director on 9/10/2021 on Behavior Management. (See attachment in-service documentation and collateral)

A resident with tendencies to eloping behaviors will have those behaviors and appropriate interventions placed on their support plan. The support plan will be available for staff review. Resident support plans will be available for survey review.

Staff will be in-serviced by the Executive Director on 9/14/21 and 9/16/21 regarding regulation 201, appropriate verbal approaches, and Safe Management Techniques. In-Service Documentation will be forwarded after completion. (See attachment- collateral)

Staff will be in-serviced by the Executive Director on a monthly basis (September – December) on regulation 201, appropriate verbal approaches and Safe Management Techniques. In-service records will be available for survey review.

Completion Date: *09/12/2021*

Document Submission **Implemented**

Please find collateral and in-service documentation for in-service on 9/14/21 & 9/16/21.

234d - Support Plan Revision

1. **Requirements**

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

234d - Support Plan Revision *(continued)*

Description of Violation

A support plan for resident #1, was completed on [redacted] However, on [redacted] resident #1 had an incident involving pulling a fire alarm and eloping from the home. The support plan was not updated to reflect the elopement techniques and precautionary measures to intervene when this behavior was displayed by the resident.

Plan of Correction **Accept**

The Executive Director or designee will review current resident support plans by 10/15/21 to ensure they reflect the individual's current conditions and approaches. A resident roster with review signature and date will be available for survey review.
The Executive Director or designee will revise the resident's support plan at least annually and as the resident's condition changes. The RASP Update Log will be completed daily to ensure compliance. (See attachment – RASP Update Log). Dates – 9/15/21 through 12/15/21. The Log will be available for survey review.
The coordinators and nursing supervisors were in-serviced by the Executive Director on 9/8/21 and 9/9/21 regarding regulation 234.d. and the RASP Update Log. (See attachment – In-service documentation and collateral)

Completion Date: *09/12/2021*

Document Submission **Implemented**

NA