Department of Human Services
Bureau of Human Service Licensing

September 13, 2021

[redacted] COO
IVQ LANSDALE OPCO LP
765 SKIPPACK PIKE, SUITE 300
BLUE BELL, PA 19422

RE: TRADITIONS OF LANSDALE
1800 WALNUT STREET
LANSDALE, PA, 19446
LICENSE/COC#: 14521

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/10/2021 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

September 7, 2021

[redacted] COO
IVQ LANSDALE OPCO LP
765 SKIPPACK PIKE, SUITE 300
BLUE BELL, PA 19422

RE: TRADITIONS OF LANSDALE
1800 WALNUT STREET
LANSDALE, PA, 19446
LICENSE/COC#: 14521

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 08/10/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations 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: *TRADITIONS OF LANSDALE* **Licen e #**: *14521* **Licen e Expiration Date**: *02/28/2022*
Addre : *1800 WALNUT STREET, LANSDALE, PA 19446*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *2158551235* **Email**: [redacted]

Legal Entity

Name: *IVQ LANSDALE OPCO LP*
Address: *765 SKIPPACK PIKE, SUITE 300, BLUE BELL, PA, 19422*
Phone: *2158551235* **Email**: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *81* **Waking Staff**: *61*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Complaint* **Exit Conference Date**: *08/10/2021*

Inspection Dates and Department Representative

08/10/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *38* **Residents Served**: *13*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *24* **Have Physical Disability**: *1*

Inspections / Reviews

08/10/2021 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/06/2021*

Inspections / Reviews *(continued)*

9/7/2021 - POC Submission

Lead Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow-Up Date:** *09/13/2021*

9/13/2021 Document Submi ion

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

42u - Right to Remain in Home

1. Requirements

2600.

42.u. A resident has the right to remain in the home, as long as it is operating with a license, except as specified in § 2600.228 (relating to notification of termination).

Description of Violation

On [redacted], the home discharged resident #1 against resident's wishes. Resident was evaluated at the hospital on [redacted] and was cleared to return to the facility, however, the home refused to accept resident back.

Plan of Correction **Accept**

42u - Right to Remain in Home

- How: It is not our intent to discharge residents for whom we are able to keep them safe and meet their needs. In this circumstance, the resident was sent to the hospital for evaluation following two incidents in one day. In the first incident, the resident left the community and was returned by a police officer who found them walking on the road. Following that incident, the resident became combative and exhibited behaviors that were potentially dangerous to others. Our goal in seeking evaluation was to determine if there were any physical or psychological conditions or issues that were contributing to these changes, as the resident had never done anything like this previously.

- Who: Executive Director or designee

- When: Training will be completed by 9/30/21.

- How: Prior to returning from the hospital evaluation for serious issues, residents should be assessed to confirm their safety and care needs are able to be met. Should additional services be needed, such as 1:1 care or a transfer to the secured Memory Care Neighborhood, that will be communicated with the hospital to allow time to set up such services and complete all communication and documentation required by the State. The Executive Director will review with all care staff who might be responsible for discussing transfers with the hospital the need for clear communication about all of this. These team members will sign off on Training Sheet acknowledging their understanding (Attachment A).

- Ongoing: Resident Care Director or designee will reassess residents before returning to the community and/or receive documentation from the hospital describing the treatment provided to ensure we are able to meet residents needs upon returning to community.

Resident Care Director or designee will discuss with hospital staff our process to ensure we are able to meet the resident's safety and care needs, and engage in active communication related to our timeline and expectations to be able to confirm our ability to accept the resident back into the community. In addition, dialogue to update hospital staff as the community team sets up any necessary supports will be ongoing. All discharges will be reviewed at the Quarterly QA meetings.

Completion Date: *09/30/2021*

Document Submission **Implemented**

Education provided to staff. See attached- Completed Education.

228h - Grounds Discharge/Transfer

1. Requirements

2600.

228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

1. If a resident is a danger to himself or others.
2. If the legal entity chooses to voluntarily close the home, or a portion of the home.

228h - Grounds Discharge/Transfer *(continued)*

3. If a home determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the home. If a resident or the resident's designated person disagrees with the home's decision to discharge or transfer, consultation with an appropriate assessment agency or the resident's physician shall be made to determine if the resident needs a higher level of care. A plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/intellectual disability program or drug and alcohol program, for assistance. The administrator shall also contact the Department's personal care home regional office.
4. If meeting the resident's needs would require a fundamental alteration in the home's program or building site, or would create an undue financial or programmatic burden on the home.
5. If the resident has failed to pay after reasonable documented efforts by the home to obtain payment.
6. If closure of the home is initiated by the Department.
7. Documented, repeated violation of the home rules.

Description of Violation

On [redacted], the home discharged resident #1 against the resident's will. The resident was sent to the emergency room for evaluation for a change in mental status. Resident was evaluated and determined to have no medical need requiring admission to the hospital and needed to be transported back to the personal care home. The home refused to accept the resident back into the facility and effectively discharged the resident. The resident was not discharged for any of the permitted conditions.

Plan of Correction **Accept**

228h - Grounds for Discharge/Transfer

- How: It is not our intent to discharge residents for whom we are able to keep them safe and meet their needs. In this circumstance, the resident was sent to the hospital for evaluation following two incidents in one day. In the first ncident, the resident left the community and was returned by a police officer who found them walking on the road. Following that incident, the resident became combative and exhibited behaviors that were potentially dangerous to others. Our goal in seeking evaluation was to determine if there were any physical or psychological conditions or ssues that were contributing to these changes, as the resident had never done anything like this previously.

- Who: Executive Director or designee

- When: Training will be completed by 9/30/21.

- How: Prior to returning from the hospital evaluation for serious issues, residents should be assessed to confirm their safety and care needs are able to be met. Should additional services be needed, such as 1:1 care or a transfer to the secured Memory Care Neighborhood, that will be communicated with the hospital to allow time to set up such services and complete all communication and documentation required by the State. The Executive Director will review with all care staff who might be responsible for discussing transfers with the hospital the need for clear communication about all of this. These team members will sign off on Training Sheet acknowledging their understanding (Attachment A).

- Ongoing: Resident Care Director or designee will reassess residents before returning to the community and/or receive documentation from the hospital describing the treatment provided to ensure we are able to meet residents needs upon returning to community.

Resident Care Director or designee will discuss with hospital staff our process to ensure we are able to meet the resident's safety and care needs, and engage in active communication related to our timeline and expectations to be able to confirm our ability to accept the resident back into the community. In addition, dialogue to update hospital staff as the community team sets up any necessary supports will be ongoing. All discharges will be reviewed at the Quarterly QA meetings.

Completion Date: *09/30/2021*

228h - Grounds Discharge/Transfer *(continued)*

Document Submission **Implemented**

See Attached.

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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on 9/21/20.

Plan of Correction **Accept**

234a - Admission Support Plan

- What: Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on 9/21/20.

- Who: Memory Care Director or Designee.

- When: Memory Care Director or Designee will complete audit by 9/30/21

- How: Memory Care Director or Designee will complete an audit to ensure all current residents in our Secured Dementia Unit have a support plan completed within 72 hours of being admitted.

- Ongoing: Memory Care Director or Designee will use form tracker report in Tabulapro in order to keep track of forms due. the initial support plan being due within 72 hours will appear on the TabulaPro Dashboard, and on the tracking sheet of tasks to be done for new admissions. Resident records are reviewed every month as part of your QA process (Attachment A).

Completion Date: *09/30/2021*

Document Submission **Implemented**

N/A