

Department of Human Services
Bureau of Human Service Licensing

November 29, 2022

[REDACTED]
NORTH WALES 1089 MC BG OPCO LLC
[REDACTED]
[REDACTED]

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 08/25/2021, 08/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

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 **License #:** 14256 **License Expiration:** 10/02/2021
Address: 1089 HORSHAM ROAD, NORTH WALES, PA 19454
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: NORTH WALES 1089 MC BG OPCO LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 07/19/1996 **Issued By:** Montgomery Township
Type: I-2 **Date:** 01/26/2017 **Issued By:** Montgomery Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 58 **Waking Staff:** 44

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 08/26/2021

Inspection Dates and Department Representative

08/25/2021 - On-Site: [REDACTED]
 08/26/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 48 **Residents Served:** 29

Secured Dementia Care Unit

In Home: Yes **Area:** Memory Care **Capacity:** 48 **Residents Served:** 29

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 29
Diagnosed with Mental Illness: 29 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 29 **Have Physical Disability:** 0

Inspections / Reviews

08/25/2021 - Full

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*

Follow Up Date: *12/09/2021*

11/29/2022 POC Submission

Submitted By: [REDACTED]

Date Submitted: *12/09/2021*

Reviewer: [REDACTED]

Follow Up Type: *Document Submission* Follow Up Date: *07/27/2022*

11/29/2022 Document Submission

Submitted By: [REDACTED]

Date Submitted: *11/29/2022*

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

The report incident about residents 1 and 2 arguing, dated 3/28/21, is missing the date and time.

Repeated Violation – 11/12/2020

POC Submission

Accept

- On 12/09/21 the Executive Director (ED) recorded the date and time to the original reportable incident report as a late entry and resubmitted the report to the Department’s regional office (Exhibit 00 - Copy of incident report submission)
- On 12/07/21 the Regional Director of Care Services (RDSCS) educated the ED and Care Services Manager (CSM) on the requirements set within regulation 2600.16c. (Exhibit A1- In-service)
- By 12/10/21, the ED or designee will audit current resident reportable incident reports that occurred over the preceding 90 days to validate that they were thoroughly completed. For reports identified to contain omitted information, they will be updated as late entries and resubmitted to the Department’s personal care home regional office. (Exhibit A2 – Audit tool)
- The ED or designee will review reportable resident incident reports weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 to validate they are thoroughly completed and are in compliance with regulation 2600.16c. (Exhibit A3- 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.

Licensee's Plan Completion Date: 12/09/2021

Implemented (█) - 11/29/2022)

85e - Trash Outside Home

2. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

Outside the house on 08/26/21, there was a sofa next to the dumpster.

POC Submission

Accept

- On 08/26/21, the sofa located next to the dumpster was removed from the community’s premises by the trash vendor.
- On 12/07/21, the Regional Executive Director (RED) educated the ED, CSM and Maintenance Technician (MT) on the requirements set within regulation 2600.85e. (Exhibit B1- In-service)

85e - Trash Outside Home (continued)

- The ED or designee will evaluate the dumpster and its perimeter twice weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure the dumpsters are covered and no discarded objects were left outside of the dumpster. (Exhibit B2- 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 the month of compliance.
- Completion date 12/09/2021.

Licensee's Plan Completion Date: 12/10/2021

Implemented (█ - 11/29/2022)

102f - Towel/Washcloth/Soap

3. Requirements

2600.

102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

On 08/26/21, in the north wing shower bathroom, there was a common hand towel on the towel bar.
 On 08/26/21, in the north wing shower bathroom, there was a common towel hanging on the shower tub.

POC Submission

Accept

- Completion date 12/09/2021. • On 8/26/21 the ED removed both common towels from the north wing shower bathroom.
- On 12/09/21 the RED educated the ED and CSM on the requirements set within regulation 2600.85e. (Exhibit C1- n-service)
- By 12/15/21 the CSM educated direct care staff on the requirements set within regulation 2600.85e. (Exhibit C2- In-service)
- On 12/09/21 the ED checked the north wing shower room to ensure no common use towels were present. (Exhibit C3 – Audit tool)
- ED or designee will check the shower bathrooms three times per week x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to ensure no common use towels were contained within the shower bathrooms. (Exhibit C4- Audit Tool)

102f - Towel/Washcloth/Soap (continued)

- Completion date 12/09/2021.

Licensee's Plan Completion Date: 12/09/2021

Implemented (████) - 11/29/2022)

130h Inoperable Smoke Detector

4. Requirements

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

POC Submission

Accept

- On 12/09/2021 the RED educated the ED on the requirements set within 2600.130.h and the Enlivant Crisis Binder, section 6.1 Interruption of services, subsection Fire Watch, procedure dated 2019. (Exhibit D1 – In-service)
- On 12/09/2021 the ED validated that the homes Crisis Binder contains emergency procedures that are to be immediately implemented upon the homes smoke detector or fire alarm becoming inoperable. (Exhibit D2 – Crisis binder section 6.1, *next to fire watch)
- On 12/13/2021 the ED educated the Community Leadership team on requirements set within 2600.130.h and the Enlivant Crisis Binder, section 6.1 Interruption of Services, subsection Fire Watch procedure dated 2019. (Exhibit D3 – n-service)

Licensee's Plan Completion Date: 12/09/2021

Implemented (████) - 11/29/2022)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

- 141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
 4. Special health or dietary needs of the resident.
 5. Allergies.
 6. Immunization history.
 7. Medication regimen, contraindicated medications, medication side effects and the ability to self administer medications.
 8. Body positioning and movement stimulation for residents, if appropriate.
 9. Health status.
 10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident 3’s medical evaluation did not include a medication regimen, contraindicated medications, or medication side effects.

POC Submission

Directed

- *On 12/09/21 the Executive Director (ED) recorded the date and time to the original reportable incident report as a late entry and resubmitted the report to the Department’s regional office (Exhibit 00 - Copy of incident report submission)*
- *On 12/07/21 the Regional Director of Care Services (RDCS) educated the ED and Care Services Manager (CSM) on the requirements set within regulation 2600.16c. (Exhibit A1- In-service)*
- *By 12/10/21, the ED or designee will audit current resident reportable incident reports that occurred over the preceding 90 days to validate that they were thoroughly completed. For reports identified to contain omitted information, they will be updated as late entries and resubmitted to the Department’s personal care home regional office. (Exhibit A2 – Audit tool)*
- *The ED or designee will review reportable resident incident reports weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 to validate they are thoroughly completed and are in compliance with regulation 2600.16c. (Exhibit A3- 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.*
- *Completion date 12/10/2021.*

DIRECTED ■ **7/25/22**

- ***The ED or DON will insure all required elements of the DME will be contained on all resident DME’s by reviewing the document upon completion, starting immediately,***
- ***Resident #3’s DME will be updated to reflect their list of medications and effects, within the next 15 days of receipt of this plan of correction.***

141a 1-10 Medical Evaluation Information (continued)

- **The Ed or DON will conduct an audit of all resident DME's annually to ensure all required elements are noted on the DME's, starting immediately.**

Directed Completion Date: 12/09/2021

Implemented (████) - 11/29/2022)

185a - Implement Storage Procedures

6. 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

- PRN prescription for Resident 2, ██████████ by mouth every two hours as needed for ██████████ or ██████████, dated ██████████/2021, Qty 5. Staff A signed off on 40 syringes as the quantity received: The narcotics book contained a record of 15 Syringes administered; however, the narcotics lock box contained only 24 Syringes. There was 1 ██████████ syringe missing.
- PRN prescription for Resident 2, ██████████ by mouth every two hours as needed for ██████████ or ██████████, dated ██████████/2021, Qty 2.500. Staff A signed off on 20 syringes as the quantity received. The narcotics book contained a record of three syringes administered; however, the narcotics lock box contained only sixteen syringes. There was 1 ██████████ syringe missing.
- PRN prescription for Resident 2, ██████████ by mouth every two hours as needed for ██████████ or ██████████ dated ██████████/2021. Staff A signed and dated 50 syringes as "quantity received" ██████████. A blank record card was in the narcotics book; however, the medication (50 syringes) was not in the narcotics lock box.
- ██████████, PRN prescription for Resident 4, take one tablet every four hours as needed for ██████████ or ██████████, dated ██████████/2020, Qty 30. On ██████████ 2021, Staff A signed and dated 60 tablets as "quantity received." The narcotics book had a blank record card, but the medication was missing from the narcotics lock box. Sixty tablets were missing.

POC Submission

Accept

- Resident #2 and #4 did not sustain a negative effect related to this finding.
- On 08/26/21 the CSM determined a medication technician administered the sixteenth administration of resident #2 prefilled ██████████ syringe (0.25ml 5mg) by referring to Resident #2's Medication Administration Record and interviewing the medication technician who documented the administration. The medication technician then documented the removal of the ██████████ syringe on the inventory record as a late entry. (Exhibit F1- Narc inventory sheet)
- On 08/26/21 the CSM inventoried current resident's narcotic inventories and discovered the prefilled ██████████ syringe (0.25ml 5mg) belonging to Rx 807406733. The syringe was returned to Resident #2 inventory, reconciling the inventory of 17 prefilled syringes.
- On 08/27/21 the CSM determined narcotic prescription numbers and their associated inventory counts were being inappropriately comingled for residents with multiple orders and or multiple blister cards.
- On 8/27/21 the CSM educated the medication technicians on the requirements set with 2600.185a and on the handling and storage of controlled medications. (Exhibit 00 – in-service)
- On 8/27/21 the CSM reconciled the controlled medication inventories and records for current residents, including

185a - Implement Storage Procedures (continued)

resident #2 and #4.

- On [REDACTED]/2021, upon receipt of the Departments Violation Report, the Regional Director of Care Services (RDCS) conducted a comprehensive review of Resident #2 and #4 narcotic inventory records and validated that controlled medications corresponding to different prescription numbers and standing, and as-needed orders were previously being comingled within the narcotic drawer and their associated inventory counts were being combined on narcotic records. The combining of inventories for resident #2's [REDACTED] inventory contributed to the medications documented removal to occur on a different inventory form belonging to resident #2. The combining of inventories for resident #4's [REDACTED] contributed to the medications documented removal to occur on a different inventory form belonging to resident #4. (Exhibit F2 -inventory forms)
- The CSM or designee will audit current resident narcotic inventory records and corresponding on-hand inventory 3 x weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit F3 – 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.
- Completion date 12/09/2021.

Licensee's Plan Completion Date: 12/09/2021

Implemented [REDACTED] - 11/29/2022)

231c - Preadmission Screening**7. 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.

Description of Violation

Resident 3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/2021. However, the resident's written cognitive preadmission screening is not dated.

POC Submission

Accept

- Resident #3 did not sustain a negative effect related to this finding.
- On [REDACTED]/2021, the CSM updated Resident #3's preadmission screening with a late entry to indicate the date in which it was completed. (Exhibit G1- Updated preadmission screening)
- On 12/09/2021 the ED educated the CSM on the requirements set within regulation 2600.231.c. (Exhibit G2-in-service)
- By 12/15/2021, the CSM and/or designee will audit current resident preadmission screenings for omitted documentation. Omitted documentation identified will be completed as a late entry by a licensed nurse. (Exhibit G3-audit tool)
- The CSM or designee will audit new admission preadmission screenings weekly for omitted documentation x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate compliance. (Exhibit G4- audit tool- same as 225.a)
- 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.

231c - Preadmission Screening (*continued*)

Licensee's Plan Completion Date: 12/09/2021

Implemented (SW - 11/29/2022)

251b - Record Entries Legible

8. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

- On [REDACTED]/2021, a staff member A signed and dated prescription RX:807406733, indicating a quantity of 50 tablets received in the resident's 2 narcotics book; however, the quantity is overridden in the narcotics record.
- A staff member A signed prescription RX:807406733, indicating a quantity of 20 tablets received in the resident's 2 narcotics book; however, the quantity is overridden in the narcotics record.
- On [REDACTED]/2021, a staff member A signed and dated prescription RX:36410185, indicating a quantity of 30 tablets received in the resident's 4 narcotics book; however, the quantity is overridden in the narcotics record.

POC Submission**Accept**

- Resident #2 and #4 did not sustain a negative affect related to this finding.
- On 12/07/2021 the RDCS educated the CSM on the requirements set within regulation 2600.251.b. (Exhibit H1 – In-service)
- By 12/13/2021 the CSM educated the Medication Technicians on the requirements set within regulation 2600.251.b, in addition to the management of controlled medication handling and storage.
- On 12/13/2021 the CSM reviewed the narcotic inventory sheets of current residents, documentation practices reflected compliance. (Exhibit H2- Audit tool)
- On 11/30/2021 upon receipt of the Departments Violation Report, the Regional Director of Care Services (RDCS) conducted a comprehensive review of Resident #2 and #4 narcotic inventory records, including the records associated with Rx 807406733 and Rx R36410185, and concluded that controlled medications corresponding to different prescription numbers and standing and as-needed orders were previously being comingled within the narcotic drawer and their associated inventory counts were being combined on narcotic inventory records. Furthermore, the RDCS determined the quantities originally documented on the narcotics record became inappropriately and erroneously overridden for resident #2 and #4 when medication technicians combined medication counts on narcotic inventory records.
- The CSM or designee will audit the narcotic inventory records of current residents 3 x weekly x 4 weeks, then bi-weekly x 4 weeks, the monthly x 1 to validate sustained compliance.
- 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.

Licensee's Plan Completion Date: 12/09/2021

Implemented ([REDACTED] - 11/29/2022)