Department of Human Services
Bureau of Human Service Licensing

November 9, 2021

[redacted], ADMINISTRATOR
HUMANGOOD PENNSYLVANIA
2002 JOSHUA ROAD
LAFAYETTE HILL, PA 19444

RE: SPRING MILL POINTE
2002 JOSHUA ROAD
LAFAYETTE HILL, PA, 19444
LICENSE/COC#: 12792

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 09/08/2021 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,
[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: *SPRING MILL POINTE* **License #:** *12792* **License Expiration Date:** *12/15/2021*
Address: *2002 JOSHUA ROAD, LAFAYETTE HILL, PA 19444*
County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *6108284848* **Email:** [redacted]

Legal Entity

Name: *HUMANGOOD PENNSYLVANIA*
Address: *2002 JOSHUA ROAD, LAFAYETTE HILL, PA, 19444*
Phone: *6108284848* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *10/15/2007* **Issued By:** *Whitemarsh Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *78* **Waking Staff:** *59*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *09/08/2021*

Inspection Dates and Department Representative

09/08/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *107* **Residents Served:** *50*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Cedar Grove* **Capacity:** *33* **Residents Served:** *26*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *49*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *28* **Have Physical Disability:** *0*

Inspections / Reviews

11/1/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date**: *11/06/2021*

11/9/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date**: *11/24/2021*

42s - Privacy

1. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 9/8/21, at 3:36 pm, there was a camera in room #144. The home has a fall detection monitoring system, that records the resident which violates the privacy of the residents in the room.

Plan of Correction **Accept**

SafelyYou is actively working with the Pennsylvania Department of Human Services to demonstrate how this technology, with proper releases from powers of attorney, meets the regulatory requirements. Until the PA Department of Human Services acknowledges that the system meets the regulatory requirements, the cameras will not be used at Spring Mill Pointe. Personal care home administrator and executive director, will ensure that this plan of correction is followed.

Completion Date: *10/15/2021*

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home had 5 contractors in the building completing renovations without criminal background checks since the end of May 2021.

Plan of Correction **Accept**

Community has collected criminal background checks for the five contractors -Attached-, and has confirmed that the construction company is aware that criminal background checks must be run and maintained in accordance with the regulations. Director of Building and Grounds/ designee, will contact construction company on a monthly basis for the next six months to ensure compliance, and will report findings monthly to QA.

Completion Date: *11/02/2021*

82a - Poisonous Materials

1. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 9/8/21, at 9:50 am, in Cedar Brook there was an unlabeled bottle of cleaner, unsecured on the housekeeping cart.

82a - Poisonous Materials *(continued)*

Plan of Correction **Accept**

An audit of the housekeeping carts was completed to ensure that all chemicals and poisonous materials are stored in their original, labeled containers. Housekeeping team was re-educated on regulation 82a. Moving forward, the housekeeping manager/designee will conduct random audits and the results will be reported monthly to QA. See attached.

Completion Date: *09/10/2021*

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

Bleach Germicidal Wipes and Flex Disinfectant Wipes, with a manufacture's label indicating "Call a poison control center or doctor immediately for treatment advice", was unlocked, unattended, and accessible to residents in Cedar Brook memory care unit. Not all the residents of the home, including the residents in memory care, have been assessed capable of recognizing and using poisons safely.

Plan of Correction **Accept**

An audit of the memory care neighborhood was completed to ensure that all poisonous materials are kept locked and inaccessible to residents. Housekeeping team was re-educated on regulation 82c. Moving forward, the housekeeping manager/designee will conduct weekly audits and the results will be reported monthly to QA. See attached.

Completion Date: *09/10/2021*

85a - Sanitary Conditions

1. **Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/8/21, at 10:13 am, a sticky substances was observed in the bottom of the refrigerator located in memory care kitchen. At 3:36 pm, the mattress in room #144 dispelled a strong odor of incontinence. At 3:36 pm, room #151 had a strong odor of urine, there were soiled clothing with gnats flying around in the shower.

85a - Sanitary Conditions *(continued)*

Plan of Correction **Accept**

A refrigerator detailed cleaning was completed. Director of Dining Services/designee will conduct weekly audits and results will be discussed monthly in QA. dining staff will have schedule for routine cleaning of all refrigerators. Room 144 was detailed by housekeeping including ensuring a mattress cover was on. Room 151 was detailed cleaned, the team was re-educated on bagging and sealing soiled items and to remove promptly. Housekeeping manager/designee will conduct weekly random rounds to ensure sanitary conditions. Results will be discussed monthly in QA. See attached.

Completion Date: *09/08/2021*

86a - Ventilation

1. **Requirements**

2600.

86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

On 9/8/21, resident rooms 144 and 151, had no operable window, fan, air conditioner or other mechanical ventilation to ensure airflow.

Plan of Correction **Accept**

Resident rooms 144 and 151 both have an operable window and PTAC units. It was noted that both private bathrooms needed a repaired exhaust fan. Repair was completed on 10/1/21. Director of Building/designee will conduct random monthly audits to ensure exhaust fans are operable. Results will be reported to QA. See attached.

Completion Date: *09/14/2021*

91 - Telephone Numbers

1. **Requirements**

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in room #106.

Plan of Correction **Accept**

Emergency Telephone numbers are posted by each telephone with an outside line attached to the phone cord via a zip tie. A house audit was conducted and it confirms the placement. Director of building/designee will conduct a monthly audit and report to QA for the next six months.

Completion Date: *11/02/2021*

96a - First Aid Kit

1. **Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

96a - First Aid Kit *(continued)*

Description of Violation

The home did not have a first aid kit that included gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings, and tweezers; located in the memory care unit.

Plan of Correction **Accept**

The home does have a first aid kit that includes all the required items at the front desk. This is communicated to team members and posted at a variety of locations in the home. Based on the surveyor's recommendation, a first aid kit was added to the memory care neighborhood. The safety committee will verify both locations monthly and report to QA. It is our position that we are in compliance with this regulation. We respectfully request to withdraw this violation.

Completion Date: *10/13/2021*

96b - First Aid Location

1. **Requirements**

2600.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

The staff in memory care unit, did not know the location of the first aid kit.

Plan of Correction **Accept**

Team members have been educated on location of the first aid kit- attached. This will continue to be a part of new team member orientation moving forward. Director of Resident Services/designee will train team members monthly on location of the first aid kit, and will report monthly to QA.

Completion Date: *11/02/2021*

103g - Storing Food

1. **Requirements**

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 9/8/921, there were opened and unsealed cups of what appeared to be ice cream and opened and unsealed applesauce in the refrigerator.

Plan of Correction **Accept**

A detailed cleaning of the refrigerator was completed on 9/08/2021 All items were removed. Nursing team and dining services team were re-educated on the 103g regulation- please see attached.
Dining Director/designee will conduct weekly audits to ensure compliance with regulation 103g. Results will be reported monthly to QA.

Completion Date: *09/10/2021*

183e - Storing Medications

1. **Requirements**

2600.

183e - Storing Medications *(continued)*

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 9/8/21, at 11:58 am, there were two loose pills in the medication cart located in memory care unit, Cedar Brook.

Plan of Correction **Accept**

A cart audit was completed, and all loose pills were removed. Nursing team was re-educated on proper storage of prescription and OTC medication under regulation 183e. Director of Resident Services/designee will conduct random audits to ensure compliance with regulation 183e, and will report results monthly to QA. See attached.

Completion Date: *10/11/2021*

184a - Labeling OTC/CAM

1. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

There was no pharmacy label for Medline Skintegrity wound cleanser.

Plan of Correction **Directed**

The medline Skintegrity cleanser is not a prescription, but rather is a house stock item that is used as needed to provide first aid. Per surveyor recommendation the cleanser has been relocated to the nurses office. Director of Resident Service/Designee will conduct monthly audit to ensure the house stock cleanser is in the nurses office, and will report monthly to QA.

Directed

Within 10 calendar days of receipt of the acceptable plan of correction - A designee qualified to administer medications will complete an initial and monthly audit of the medication carts and any other medication storage areas to ensure all prescription medications are labeled with a pharmacy label, to include: the resident's name, medication name, date prescription issued, prescribed dosage and instructions for administration and name and title of the prescriber and match the prescription.

Within 15 calendar days of receipt of the acceptable plan of correction- All staff persons administering medications will be re-educated on the requirements of this regulation including OTC medications and CAM belonging to residents are identified with the residents name. Documentation of education will be kept. [redacted] *11/9/21*

Completion Date: *11/02/2021*

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

The glucometer for resident #1 had numbers that were not documented correctly on the medication administration record they as follows:
On 9/5/21, at 6:14 am, the glucometer displayed 100 this was not documented on the medication administration record.
On 8/17/21, at 11:55 am, the glucometer displayed 196; however 197 was documented on the medication administration record.
On 8/20/21, at 3:22 pm, the glucometer displayed 162; however 184 was documented on the medication administration record.
On 8/26/21, at 7:07 am, the glucometer displayed 119; however 174 was documented on the medication administration record.

Plan of Correction **Accept**

Glucometers calibration and quality checks were implemented, weekly audits will be performed and reported monthly to QA. Nursing team were re-educated on regulation 185a. Weekly audits will be performed to ensure glucometers readings are documented correctly, results will be reported monthly to QA. See attached.

Completion Date: *10/13/2021*

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.

Description of Violation

Resident #2's most recent assessment was completed on [redacted]

Plan of Correction **Accept**

A chart review audit was completed. Director of Resident Service and Personal Care Manager were re-educated on regulation 225c. see attached. Moving forward, a random monthly chart review will be performed by director of resident services/designee to ensure compliance. Results will be reported monthly to QA. See attached.

Completion Date: *09/13/2021*

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 #3 participated in the development of his/her support plan on [redacted]*. However, the resident did not sign the support plan.*

227g -Support Plan Signatures *(continued)*

Plan of Correction **Accept**

A support plan audit was completed. Personal Care Manager was re-educated on regulation 227g. see attached. Moving forward, a random monthly support plan review will be performed by director of resident services/designee to ensure compliance. Results will be reported monthly to QA. See attached.

Completion Date: *09/13/2021*

227h - Support Plan Refuse Sign

1. **Requirements**

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #3 participated in the development of [redacted] support plan on [redacted]. The home did not document the resident refusal to sign the support plan. The home did not make a notation regarding the resident's inability to sign.

Plan of Correction **Accept**

A support plan audit was completed. Personal Care Manager was re-educated on regulation 227h. see attached. Moving forward, a random monthly support plan review will be performed by director of resident services/designee to ensure any refusals are documented. Results will be reported monthly to QA. See attached.

Completion Date: *09/13/2021*

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

The directions for operating the home's locking mechanism was not conspicuously posted near the door located by the administrative hallway of the Secure Dementia Care Unit (SDCU).

Plan of Correction **Accept**

We installed signs in Cedar Grove to share the code to the door at a conspicuous location near the device. Please see attached picture.

Completion Date: *09/08/2021*

251b - Record Entries Legible

1. **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

Correction fluid was used on resident #4's contract dated [redacted].

251b - Record Entries Legible *(continued)*

Plan of Correction **Accept**

An electronic contract system that generates dates electronically was implemented in 2021. Sales Director was educated on this policy. See attached. Random audits will be performed and results will be reported monthly to QA.

Completion Date: *09/10/2021*