

Department of Human Services
Bureau of Human Service Licensing

October 19, 2021

[REDACTED]
FOULKEWAYS AT GWYNEDD
1120 MEETING HOUSE ROAD
GWYNEDD, PA 19436

RE: FOULKEWAYS AT GWYNEDD
1120 MEETING HOUSE ROAD
GWYNEDD, PA, 19436
LICENSE/COC#: 12774

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 09/21/2021 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,
Mia Johnson

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: *FOULKEWAYS AT GWYNEDD* License #: *12774* License Expiration Date: *08/27/2022*
Address: *1120 MEETING HOUSE ROAD, GWYNEDD, PA 19436*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: *2156432200* Email: [REDACTED]

Legal Entity

Name: *FOULKEWAYS AT GWYNEDD*
Address: *1120 MEETING HOUSE ROAD, GWYNEDD, PA, 19436*
Phone: *2156432200* Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *80* Waking Staff: *60*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *09/21/2021*

Inspection Dates and Department Representative

09/21/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* Residents Served: *79*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *79*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1* Have Physical Disability: *1*

Inspections / Reviews

09/21/2021 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/16/2021*

Inspections / Reviews *(continued)*

10/19/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *10/22/2021*

42c - Treatment of Residents

1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 9/9/2021, Staff Person A argued with Resident 1 over a medication the resident stated [REDACTED] did not receive. Staff person A stated she administered the medication to the resident at 5:00 pm in the dining room. However the resident stated [REDACTED] was not in the dining room at that time and did not receive the medication. The staff person became very argumentative and aggressive with the resident about this medication. The resident continued to tell the staff person that [REDACTED] did not take the medication because [REDACTED] was not in the dining room at 5:00 pm. The resident began to feel disrespected and uncomfortable and just wanted the staff person to leave [REDACTED] room and to leave [REDACTED] alone.

On 9/9/2021, Staff Person A arrived very late to Resident 2's room to administer [REDACTED] eye drops. Upon arrival to [REDACTED] room, [REDACTED] told the resident that [REDACTED] was outside her room for a few minutes waiting until [REDACTED] was exactly 1 hour late. Staff person A stated to the resident "you don't tell me what to do I tell you what to do I'm the nurse". The staff person proceeded to tell the Resident that [REDACTED] now knows why she never had any children because [REDACTED] likes to get all the attention to [REDACTED]. Staff person A stated to resident 2 that [REDACTED] has never cared for anyone including anyone that is ill. [REDACTED]e made the resident feel that [REDACTED] wasn't important. Resident 2 felt disrespected by the staff person and felt as if the staff person was demeaning towards [REDACTED]. Staff person A also stated to the Resident that other residents medications are more important than [REDACTED] eye drops.

Plan of Correction

Accept

Staff Person A had prior Respect, Dignity, Resident Focused Care, Abuse and Neglect Training before this incident. As soon as the Residents reported the events, Foulkeways administration reported the events to DHS and Montgomery County AAA as suspected abuse. Investigation confirmed the Residents were not treated with respect and dignity. Staff person A was terminated the day after the events were reported. Foulkeways will continue to provide annual and as needed training for all staff regarding treating Residents with respect and dignity. Staff who are not compliant will be terminated immediately if progressive disciplinary steps are not warranted.

Completion Date: 09/14/2021