Department of Human Services
Bureau of Human Service Licensing

April 13, 2022

[redacted], ADMINISTRATOR
[redacted]

RE: ABINGTON MANOR AT MORGAN
HILL-MEMORY CARE VILLAGE
5 CEDAR PARK BOULEVARD
EASTON, PA, 18042
LICENSE/COC#: 22614

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/13/2021 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

Facility Information

Name: *ABINGTON MANOR AT MORGAN HILL-MEMORY CARE VILLAGE* **License #**: *22614* **License Expiration**: *02/18/2022*

Address: *5 CEDAR PARK BOULEVARD, EASTON, PA 18042*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *06/01/2010* **Issued By**: *Williams Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *52* **Waking Staff**: *39*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Incident* **Exit Conference Date**: *10/13/2021*

Inspection Dates and Department Representative

10/13/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *26*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *50* **Residents Served**: *26*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *26*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *26* **Have Physical Disability**: *0*

Inspections / Reviews

10/13/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/15/2022*

02/08/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/15/2022*

03/16/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/07/2022*

04/13/2022 - Document Submission

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

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

The home currently serves 26 residents. On 10/10 & 10/11/21 from 11pm-7am no one was certified in First Aid and CPR.

Plan of Correction ***Accept***

The facility immediately scheduled the training for both First Aid / CPR 11/5/2021 & 11/9/2022 to ensure there is at least one staff member scheduled daily for each shift that is fully certified in both FA/CPR to maintain compliance.

Moving forward the facility is working with a new program in our electronic health file that will allow us to keep track of all staff members trainings and certifications.

New hires will be entered on their hire date by the HR Associate and will then be maintained by both HR and the Administrative Assistant to maintain compliance.

The Administrator will follow up routinely to ensure compliance moving forward.

SEE attached FA/CPR sign in sheet

Completion Date: *01/21/2022*

Document Submission ***Implemented***

Compliance is an ongoing process. The facility continues to schedule CPR/FA classes to ensure there is at least one staff member on duty to 50 residents.

The facility has a new electronic health file to include staff and the Administrative Assistants will be uploading all certifications which will allow for a better tracking system to ensure compliance.

The DRC will ensure all classes are scheduled and work with the Administrative assistants with the Administrator oversite.

The facility had a class11/9/21, 3/9/22 - see attachments

There is another class scheduled for 3/31/22- at this time there is at least one staff member on each shift who is certified in both CPR/FA.

65a - FS Orientation 1st Day

1. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

65a - FS Orientation 1st Day *(continued)*

5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Agency direct care staff member A hired [redacted] did not complete the general fire safety orientation on or before the 1st day worked.

Plan of Correction ***Accept***

Staff member A was not hired by the facility and is employed by a staffing agency. At the exit interview the inspector explained the need to also have proper documentation of fire safety training completed by the Certified Fire Safe Expert with date, as well as the date the staff member was alone on the floor.

Moving forward the current First & Forty hours of training form was updated to show the above required training dates, This form will be used with each new hire and all agency staff and kept in their employee file, as well an a separate file for agency staff.

The HR Associate will be responsible to maintain all staff member files to include outside agency staff and the Administrator will oversee compliance.

See updated - First / Forty form attached that is signed by staff member A
Completion Date: *02/01/2022*

Document Submission ***Implemented***

There have been no new agency staff since our last inspection.

Please see the attached "Agency first and forty" completed form

65b - Rights/Abuse 40 Hours

1. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Agency direct care staff member A hired [redacted] did not complete training in resident rights, The Older Adult Protective Services Act, emergency medical plan or reporting of reportable incidents and conditions within the first 40 hours worked.

Plan of Correction ***Accept***

As explained in violation 65a, the First and Forty form was updated to show proper documentation of training of all new hires to include agency staff.

This First / Forty form documents the Rights/Abuse training as well.

65b - Rights/Abuse 40 Hours (continued)

The HR Associate is responsible to maintain all staff member files to include outside agencies. The Administrator will oversee compliance.

The signed First / Forty form for staff member A is attached

Completion Date: *01/24/2022*

Document Submission ***Implemented***

Please see the attached "agency first and forty" form completed.

There have been no new agency staff since our last inspection.

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

There was an Asepticare Aerosol disinfectant virucide spray available in an unlocked drawer in the common area in the home's B Wing area, accessible to residents in the secured dementia unit. The directions on the spray's label reads "IF SWALLOWED: Call a poison control center or doctor immediately for treatment advice."

Plan of Correction ***Accept***

All poisonous material must be kept locked and secured at all times. The housekeeping checklist was updated to document compliance and both housekeepers were re-educated in the importance of keeping all poisonous materials out of the reach of all residents.

This is also to include making sure the housekeeping cart is locked and monitored at all times when in use, and locked in the laundry room when not being used.

The Campus Director of Services is responsible to maintain compliance with the Administrators oversite.

**see attached Housekeeping Checklist and sign in sheet.*
Completion Date: *01/22/2022*

Document Submission ***Implemented***

Please see the attached completed "Housekeeping Checklist"

The Director of Services will be responsible to ensure all checklist are completed with the Administrators oversite to ensure compliance.

85a - Sanitary Conditions

1. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

Resident #1's glucometer was used to test Resident #2's blood glucose on [redacted] at 8am.

Plan of Correction ***Accept***

This violation was caused by an agency staff nurse and the error was immediately rectified. The meter was immediately pulled from the medication cart and replaced with a new one. The error was reported to DHS and the appropriate blood work was drawn to ensure there were no ill effects from the cross contamination.

The agency nurse was immediately re-educated on the policies regarding blood glucose monitoring in a personal care home setting. The agency was notified of the error and further directions given so all agency staff are re-educated.

All meters and cases are clearly labeled with the residents picture and name. A document was created to explain the proper protocol and will be presented to all licensed agency professionals upon entering the unit so they will be trained on the proper guidelines when testing blood glucose readings.

This policy & checklist will be scanned to the GHR Licensed Nursing agency and will ensure all non-facility staff are updated and follow the proper facility polices. All non-facility staff will also sign the checklist & policy upon first entering the facility to work.

It will be the responsibility of the DRC to ensure compliance with the Administrators oversite.

**see attached document - Glucometer checklist & Blood Glucose P-P*

Signed - sign in sheet of all licensed & Med Techs will be sent to DHS upon completion
Completion Date: *02/01/2022*

Document Submission ***Implemented***

See the attached "EMAR glucometer checklists R.B. & G.H.)

These checks are listed in the electronic EMAR program used to administer medication.
It is used as a daily reminder and keeps staff accountable to routinely monitor the glucometers to maintain safety and compliance.

If there is a meter that is not calibrated correctly or labeled correctly or the results are documented incorrectly the error will be found immediately and addressed.

It is the responsibility of the Director of Resident Care to maintain compliance with the Administrators oversite.

103i - Outdated Food

1. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

In the walk-in fridge located in the home's kitchen, there were 3 containers of Dannon Low-fat Vanilla Yogurt with a "best by" date of 10/5/21 and were therefore expired at time of inspection.

103i - Outdated Food *(continued)*

Plan of Correction ***Accept***

The Campus Director of Services has created a new checklist and policy to ensure all perishable and non-perishable products are not spoiled or outdated.

The dietary staff will be educated on the new checklist and will be held accountable.

The Campus Director of Services will be responsible for maintaining compliance with the Administrators oversite.

See the attached checklists - Sign in sheet to be scanned to DHS upon completion of training.
Completion Date: *02/01/2022*

Document Submission ***Implemented***

Please see the attached "outdated food checklist" that is currently being used to ensure compliance.

The dining staff will check the walk-in fridge daily to ensure all outdated items are removed and replaced.

The Campus Director of Services is responsible for compliance with the Administrators oversight.

183e - Storing Medications

1. Requirements

2600.
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

A loose small round pink pill labeled #262 was found in the medication cart.

Plan of Correction ***Accept***

The pharmacy contracted by the facility does monthly audits of all the medication and treatment carts during the medication auto exchange.

Moving forward the 11p-7a shift lead is also responsible for a weekly audit review of the nursing office and medication / treatment carts to ensure there are no loose, expired or missing pills or discontinued medication in the carts.

The checklist was updated and all the nursing professionals were re-educated on their job responsibilities.

The DRC is responsible for compliance with the Administrators oversite

The checklist and sign in sheet of all licensed and Med Techs will be sent to DHS upon completion.
Completion Date: *02/01/2022*

Document Submission ***Implemented***

The Medication Cart audits are done routinely on the 11p-7a shift to ensure the carts are updated and all out dated medications, creams & supplies are removed and replaced in a timely manner.

The Director of Resident care is responsible for compliance with the Administrators oversight.

184b - Resident's Meds Labeled

1. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #6's OTC Vitamin b-12 is not labeled with the residents name.

Plan of Correction ***Accept***

`To ensure all resident OTC / CAM medications are properly labeled the professional staffs checklist was updated.

All staff licensed and trained to administer medication via the DHS approved program were re-educated on the proper procedures when accepting and administering OTC medications.

The DRC will be responsible to maintain compliance with the Administrators oversite.

**see attached OTC / CAM policy & procedure*

Sign in sheet from licensed and Med Techs to follow upon completion
Completion Date: *02/01/2022*

Document Submission ***Implemented***

Please see the sign in sheet and and from the meeting that was help 2/3/2022.

All staff were reeducated and the campus physician also attended the meeting and was made aware of the facility policies.

184c - Sample Prescription Meds.

1. Requirements

2600.
184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

Resident #5's sample medication [redacted] does not have the written directions from the prescriber attached. The medication is also not in its original package.

Plan of Correction ***Accept***

The process of accepting and administering sample medication was written in a policy and all licensed and DHS approved Medication Techs were re-educated.

- *No medication is to be taken from it's original container.*
- *The original "written" physicians order must be wrapped around the medication so the directions, name of the resident and medication is clear and easy to follow.*
- *Medication must not be expired and labeled correctly*

The Director of Resident Care will be responsible to ensure compliance with the Administrators oversite.

**see attached sample medication policy. The sign in sheet of staff training will follow upon completion.*
Completion Date: *02/01/2022*

184c - Sample Prescription Meds. *(continued)*

Document Submission ***Implemented***

Please see the attachment for the staff sign in sheet and agenda for the meeting held 2/3/2022 to review the policy regarding sample and prescription medication.

Also the attachment for Sample Medication policy

It is the responsibility of the Director of Resident Care to maintain compliance with the Administrators oversite.

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.

Description of Violation

Resident #3 receives blood glucose readings 4 times daily. On 10/3/21 the resident's medication record indicates readings at 11:40am, 4:50pm, and 7:56pm. These readings, however, were not available in the resident's blood glucose monitor.

Resident #1 receives blood glucose readings 3 times daily. On 10/11/21 at 8am the MAR notes a reading of 124 but the glucometer has a reading of 123.

Resident #2 receives blood glucose readings 4 times daily. On 10/13/21 at 9:47am the MAR notes a reading of 205 but the glucometer has a reading of 204.

Resident #4's PRN Mylanta was not available at the time of the inspection.

Plan of Correction ***Accept***

In this violation it appears there were documentation errors:

- *It appears that agency nurse failed to document the residents glucose readings.*
- *The incorrect readings of 205 - 204 & 124 - 123 were errors in documentation.*

Moving forward - As of 10/17/2021 a task was entered into the electronic EMAR system and the 11pm-7am shift lead is responsible to check each diabetic residents glucose readings for accuracy and then gives the report to the DRC to review. If there is an error it will then be addressed in a timely manor by the DRC.

This process will continue to be followed for every diabetic resident on glucose monitoring.

It is the responsibility of the DRC to maintain compliance with the Administrators oversite

A nursing / Med Tech meeting is scheduled 2/2/2022 to review this violation and all of our current Annual Inspection violations.

The sign in sheet of attendance will be sent to DHS upon completion.

Completion Date: *02/04/2022*

185a - Implement Storage Procedures *(continued)*

Document Submission ***Implemented***

Please see the sign in sheet and agenda for the staff meeting 2/3/2022.
Also the attachment for the "EMAR glucometer checks" used to assist the staff in completing daily checks to ensure compliance.

This will continue to be the responsibility of the DRC with the Administrators oversite

187d - Follow Prescriber's Orders

1. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #3 receives blood glucose readings 4 times daily. The resident did not receive these blood sugar readings on 10/3/21 at 12pm, 5pm, or 8pm.

Plan of Correction ***Accept***

It was brought to our attention during our annual inspection that it appears an error in glucose monitoring was made.

It appears the agency nurse on duty failed to follow the written order to take the residents glucose because the readings documented in the resident MAR were not listed in any of the glucose meters present..

The error is a reportable incident and was later reported to DHS.

Moving forward to ensure compliance 10/17/2021 a task was created in the electronic EMAR system
Completion Date: *01/22/2022*

Document Submission ***Implemented***

The agency nurse has not returned to the facility and the nursing agency was sent our glucose monitoring policy and checklist and update on the errors.

The facility has a First and Forty form that will be used to train all agency staff prior to working on the floor alone to ensure an understanding for the facilities policies and proper medication administration.

Agency nurses are not being used at the facility since our inspection.

Compliance will be a team effort and the responsibility of HR & DRC with the Administrators oversite.

231b - Medical Evaluation

1. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

231b - Medical Evaluation *(continued)*

Description of Violation

Resident #2's DME, date 7/21/21, was altered after it was completed and submitted by a qualified licensed professional to indicate the resident's need for secured dementia care and a mechanical soft diet. These alterations were not signed/dated to indicate that they were completed by a qualified licensed professional.

Plan of Correction ***Accept***

The facility currently has a new Director of Resident Care and moving forward she will be completing chart audits to ensure all resident files are compliant.

The DRC will be trained in the process of obtaining new DME's and annual medical evaluations, as well as the proper process if alterations are necessary.

See the Resident File Inspection Checklist

Completion Date: *03/01/2022*

Document Submission ***Implemented***

The DRC was trained on the process of the DMEs/RASP/Prescreens and all Wellness Department responsibilities and will continue to be supported and trained as needed moving forward.

Please see the checklist attached "DRC Training Checklist" and the completed "Quarterly Inspection Survey Checklist" is also attached.

233b - Lock Manufacturer Statement

1. Requirements

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The homes manufacturer's statement was completed by Tyco Simplex Grinnell. The manufacturer's of the lock is Yale.

Plan of Correction ***Accept***

The homes locking system was approved by DHS 6 years ago and hasn't changed. As explained and approved by the state the locking system is operated by our Security Alarm system and releases automatically in the event of a fire..

See both attachments: Yale locking information and Lock letter for MCV

Completion Date: *01/24/2022*

Document Submission ***Implemented***

See the attached Yale locking system attachment in part 1

234d - Support Plan Revision

1. Requirements

234d - Support Plan Revision *(continued)*

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #3 utilizes an enabler bar attached to their bed. Resident #3s RASP, dated [redacted] does not include the resident's need for an enabler bar.

Repeat Violation: 1/6/21

Plan of Correction ***Do Not Accept***

This violation was a clear oversite and the Director of Resident Care (DRC) was made aware and updated the RASP. Moving forward there is a new DRC being trained for compliance, The Administrator is responsible to oversee compliance.

Upon completion of training the updated RASP will be scanned to DHS
Completion Date: *02/01/2022*

Update: *02/08/2022*

Please describe the communication method between direct care staff and the DRC both up and down lines of communication to share changes/improvements/declines in function and how those changes will be addressed.

How will the information then be updated into the RASP or the addendum and by whom? How frequently? If should be a minimum of every 5 days so if a significant change is noted the Home is in compliance with the 5 day window for significant change rules for new RASPs.

Plan of Correction ***Accept***

The Campus Executive Director will meet with all of the Department Head Supervisors twice weekly Monday & Thursday to review all areas of importance to ensure the safety and care of all residents and to maintain DHS compliance. This was started 2/14/2022.
(See attached "Department Head Meeting M-Th Agenda"

The Director of Resident is then responsible to update all resident changes or updates to the RASP / Addendum, with the Administrators follow up and oversight to ensure compliance in at timely manner.

There is a daily "Shift to Shift" - Face to Face report where all updates are communicated by the Nurse or Shift Lead on duty to all Direct Care staff. The other Department Head Supervisors for each entity are responsible to follow up with their department to ensure all staff are aware of any new updates or changes.

The Campus Executive Director will restart the quarterly face to face meetings (which was stopped due to Covid) with each Department quarterly to further ensure all updates / changes to include any new facility policies are communicated to all staff on a regular basis.

Moving forward both the Director of Resident Care and Campus Executive Director will do quarterly chart audits to ensure all charts are updated and in compliance with state regulations. (See attached - Resident File Inspection Checklist)

*All quarterly audits and meetings mentioned above will be completed * January - April - July - October*. First to*

234d - Support Plan Revision (continued)

be held 4/6 & 4/7/2022 and then followed quarterly thereafter.

Completion Date: 04/07/2022

Update: 03/16/2022

Please include documentation following the 4-6-22 meeting as evidence of compliance.

You may e mail it to me at agraziano@pa.gov if you wish.
AG, 3-16-22

Document Submission ***Implemented***

Please see the attached completed "DRC training checklist".

The DRC will continue to grow and learn her new role with the guidance and oversight of the Administrator and Wellness Coordinator moving forward to ensure compliance moving forward.

The DRC is responsible for compliance with the Administrators oversight.