

Department of Human Services  
Bureau of Human Service Licensing

December 14, 2021

MARTINE MINNINGER, ED  
HIDDEN MEADOWS OPCO LLC  
8000 TOWERS CRESCENT DR,STE1425  
WHITE OAK HEALTHCARE REIT  
VIENNA, VA, 22182

RE: HIDDEN MEADOWS ON THE RIDGE  
THE LAURELS  
340 FARMERS LANE  
SELLERSVILLE, PA, 18960  
LICENSE/COC#: 14524

Dear Ms. Martine Minninger,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/09/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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: *HIDDEN MEADOWS ON THE RIDGE THE LAURELS* License #: *14524* License Expiration:  
 Address: *340 FARMERS LANE, SELLERSVILLE, PA 18960*  
 County: *BUCKS* Region: *SOUTHEAST*

**Administrator**

Name: *Martine Minninger* Phone: *2152576701* Email: *mminninger@hiddenmeadowsontheridge.com*

**Legal Entity**

Name: *HIDDEN MEADOWS OPCO LLC*  
 Address: *8000 TOWERS CRESCENT DR,STE1425, WHITE OAK HEALTHCARE REIT, VIENNA, VA, 22182*  
 Phone: *2152576701* Email: *mminninger@hiddenmeadowsontheridge.com*.

**Certificate(s) of Occupancy**

Type: *I-2* Date: *03/05/2014* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *46* Waking Staff: *35*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *11/09/2021*

**Inspection Dates and Department Representative**

*11/09/2021 - On-Site: Youn Hie Chung*

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *50* Residents Served: *23*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *the whole building* Capacity: *50* Residents Served: *23*

**Hospice**

Current Residents: *4*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *23*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *23* Have Physical Disability: *0*

**Inspections / Reviews**

**11/09/2021 - Full**

Lead Inspector: *Youn Hie Chung* Follow-Up Type: *POC Submission* Follow-Up Date: *12/02/2021*

**11/09/2021 - POC Submission**

Reviewer: *Claire Mendez* Follow-Up Type: *Document Submission* Follow-Up Date: *12/10/2021*

**Inspection Dates and Department Representative (*continued*)**

**11/09/2021 - Document Submission**

**Reviewer:** *Claire Mendez*

**Follow-Up Type:** *Not Required*

18 - Compliance With Laws

General Requirements

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home did not post influenza information in a conspicuous place as required by INFLUENZA AWARENESS ACT - ENACTMENT Act of Nov. 21, 2016, P.L. 1514, No. 173 Cl.

Document Submission

In our Laurels building, the lobby areas, hallways and other common areas throughout have been repainted recently. Unfortunately, when the painting was completed, the posters did not all get put back up. Flu posters are now back up in common areas, see attached "Flu poster" pictures  
Compliance will be monitored by administrator and reviewed during annual Quality Management meetings

Completion Date: 11/09/2021

Document Submission

Implemented

Flu posters remain intact and hanging in common areas. Laminated copies of the flu poster have been left with concierge in the event any are taken down for any reasons, staff will have access to replace.

Completion Date: 12/10/2021

88a - Surfaces

Physical Site

1. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The carpet in the common area is worn and frayed.

Document Submission

Area that is in question, has a small worn spot with fraying. HMOR has a phased capital plan for carpeting and flooring to be re-done, which unfortunately has not started at the time of this inspection.  
Until the flooring/remodel can be completed, the Director of Facilities has trimmed the fraying and fused the edges to the base flooring to make sure there are no tripping hazards. The flooring contractor is scheduled in this Saturday 12/4/21 to repair/patch the spot.

Completion Date: 12/01/2021

Document Submission

Implemented

Flooring has been patched, capital design project is being initiated and scheduled by corporate to replace carpeting/flooring in common areas of the laurels

Completion Date: 12/10/2021

103e - Left Overs

Physical Site

1. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 11/09/2021 at 10:00 AM, there was an unlabeled, undated bowl of soup in A wing service kitchen refrigerator.

Document Submission

The unlabeled food was removed at time of inspection, Dining staff have been reeducated of this requirement, signs reminding all staff have been placed on all refrigerators that labeling and dating all foods are required. Compliance will be monitored monthly by the Director of Culinary Services using a CQI tool (see attached). This will be reviewed during Laurels QMP meetings

Completion Date: 12/02/2021

Document Submission

Implemented

To promote compliance of this regulation, markers and label stickers have been placed by the refrigerators to make labeling easier for staff to label food. Compliance is being monitored by Director of Culinary Services

Completion Date: 12/10/2021

103i - Outdated Food

Physical Site

1. Requirements

2600.

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

Description of Violation

On 11/09/2021 at 10:00 AM, there were 3 bags of bread, half full, unlabeled and undated in C wing service kitchen refrigerator. One of these bags was observed with moldy bread.

Document Submission

The undated food was removed at time of inspection, Dining staff have been reeducated of this requirement, signs reminding all staff have been placed on all refrigerators that labeling and dating all foods are required. Compliance will be monitored monthly by the Director of Culinary Services using a CQI tool (see attached). This will be reviewed during Laurels QMP meetings

Completion Date: 12/02/2021

Document Submission

Implemented

To promote compliance of this regulation, markers and label stickers have been placed by the refrigerators to make labeling easier for staff to label food. Compliance is being monitored by Director of Culinary Services

Completion Date: 12/10/2021

141a 1-10 Medical Evaluation Information

Resident Health

1. Requirements

2600.

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 #1s medical evaluation dated 07/14/2021 was checked on None for special health or dietary needs when the resident needed Secured Dementia Care.

Document Submission

Nursing staff have been trained on DHS required documentation/Best Practices for Pre-Admission Screening, DME and RASPs. See attached training slides and sign in acknowledgment sheet. Director of Health and Wellness will monitor full completion of DMEs upon receipt, Executive Director will monitor compliance during monthly chart audits (see attached audit sheet)

Completion Date: 11/23/2021

Document Submission

Implemented

File audits are being completed to monitor compliance of this regulation, please see attached

Completion Date: 12/10/2021

183d - Prescription Current

Medications

1. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 11/09/2021, Latanoprost 0.005% Opht, prescribed for resident #2 who no longer resides in the home, was present in the home's medication cart.

Document Submission

Unfortunately when resident #2 was discharged, all medications were removed, however one bottle of eye drops were left undetected.

Nursing staff have been re-educated of the importance of disposing all medications at time of discharge. See nursing meeting minutes and sign off sheet.

Compliance will be monitored through Pharmacy audits quarterly and DHW will review audits at time of completion

### Medications (continued)

*Audits will be reviewed at QMP meetings*

**Completion Date:** 12/01/2021

**Document Submission**

**Implemented**

*Cart audits are being completed quarterly, however audit is not scheduled until next month. In the interim, another random audit was completed by ED to monitor compliance. See attached*

**Completion Date:** 12/01/2021

### 183e - Storing Medications

#### 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**

*On 11/09/2021, a bag of Lorazepam Syringe 0.5 mg prescribed for resident #3 was observed in the locked narcotics box. However, the manufacturer's instruction indicates that the medication should be refrigerated.*

**Document Submission**

*Ativan syringes were disposed of and new ones were replaced after inspection. A new locked medication refrigerator was placed in the med room for further usage for refrigerated narcotics. Nursing staff and med techs have been re-educated on storage of refrigerated narcotics. Please see attached nursing meeting minutes and sign off*  
*Compliance will be monitored quarterly through pharmacy med audits. Audits will be reviewed during QMP meetings*

**Completion Date:** 12/01/2021

**Document Submission**

**Implemented**

*Med audit was completed by ED, audit reviewed storage of narcotic medications. See attached. Quarterly cart/med room audit scheduled for pharmacy to conduct next month*

**Completion Date:** 12/01/2021

### 187d - Follow Prescriber's Orders

#### Medications

#### 1. Requirements

2600.

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

**Description of Violation**

*Resident #4's Lorazepam 0.5 mg order was discontinued by the physician on 10/27/2021 and then prescribed again starting 11/03/2021. However, the resident was administered this medication on 10/28/21, 10/30/21, and 10/31/21.*

**Document Submission**

*Nursing staff and med techs have been re-educated on the discontinued medication procedure. During time of discontinuation of a medication, narcotic medications are to be destroyed immediately, so this does not re-occur. Please see attached nursing meeting minutes and sign off sheet.*

### Medications (continued)

Compliance will be monitored through quarterly medication audits. audits will be reviewed by the DHW at time of audit, and at QMP meetings.

**Completion Date:** 12/01/2021

#### Document Submission

**Implemented**

Pharmacy audits are scheduled for next month, however random audit was conducted by ED to monitor compliance of this regulation. See attached audit

**Completion Date:** 12/01/2021

## 202 - Prohibitions

### Safe Management Techniques

#### 1. Requirements

2600.

202. The following procedures are prohibited:

4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

#### Description of Violation

Resident #5 is prescribed Quetiapine 25 mg every 24 hours as needed for agitation at bedtime. According to the resident's MAR, this medication was administered to resident #4 to control behaviors on 6/13/21, 6/25/21, 7/17/21, and 9/12/21

#### Document Submission

Description of violation is unclear as Resident #4 was not administered Resident #5's medications on those dates or at any time. Resident #4 was not a resident in the home at that time, as she was admitted 10/13/21 please see attached admission record for Resident #4.

Resident #5's medication, Quetiapine 25mg every 24 hours as needed for agitation was given to Resident #5 as ordered by her physician. Please see attached MAR example.

Going forward, HMOR will be sure doctors do not prescribe medications for "agitation". Resident #5's orders have been corrected to reflect an appropriate diagnosis.

Compliance will be monitored by Nursing staff daily and DHW will review during monthly MAR audits

**Completion Date:** 12/01/2021

#### Document Submission

**Implemented**

Medication audit was completed by ED, see attached to monitor compliance of this regulation.

Pharmacy has been contacted by this ED about QA regarding order entry of these types of medications and the indicated usage. Pharmacy has scheduled quarterly pharmacy consultant reviews which began in October, next review will be next month, along with quarterly cart/medication audits.

**Completion Date:** 12/01/2021

## 227g -Support Plan Signatures

### Services

#### 1. Requirements

Services (continued)

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #6 participated in the development of his/her support plan on 07/22/2021. However, the resident did not sign the support plan.

Document Submission

All staff who participate in RASP development were trained on best practices. Please see the attached DHS documentation training PowerPoint and sign in sheet.

Going forward, all residents will participate and sign his/her own RASP. DHW and ED will monitor compliance through monthly file audits. See attached file audit form

Completion Date: 11/23/2021

Document Submission

Implemented

File audits are being completed monthly to monitor for compliance

Completion Date: 12/06/2021

231c - Preadmission Screening

Secured Dementia Care Units

1. 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 #1 was admitted to the SDCU on 10/05/2021. However, the resident's written cognitive preadmission screening, completed on 10/05/2021, does not indicate the diagnosis.

Document Submission

The residents diagnosis was in the documented in the medical diagnosis section of the Pre-Admission screening tool, however it was not also written in the cognitive screening section.

Nursing staff who participate in pre-admission screen completion were trained on documentation best practices, including completion of ALL boxes, and sections of the preadmission screening tool. please see attached DHS documentation PowerPoint and training sign off. DHW or ED will monitor compliance through monthly file audits (see attached)

Audits will be reviewed during QMP meetings

Completion Date: 12/02/2021

Document Submission

Implemented

File audits are being completed to monitor for compliance of this regulation, please see attached

Completion Date: 12/06/2021

233c - Key-Locking Devices

Secured Dementia Care Units

1. Requirements

Secured Dementia Care Units (continued)

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

On 11/09/2021 at 09:50 AM, the directions for operating the home's locking mechanism are not conspicuously posted near the door from the Secure Dementia Care Unit (SDCU).

Document Submission

Directions for this door were posted on the other side of the door at entry, during time of inspection, however, the other side had been taken down during painting and had not been put back up. The directions were put back up immediately during the inspection. Please see the attached pictures. Compliance will be monitored by Administrator, and reviewed during annual Quality Management meetings

Completion Date: 11/09/2021

Document Submission

Implemented

HMOR maintains compliance of this regulation. Signage is still in place. Staff have been educated on the purpose of this regulation and compliance will be monitored by administrator during QM meetings

Completion Date: 12/10/2021

252 - Record Content

Resident Records

1. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

- 10. A record of incident reports for the individual resident.

Description of Violation

Resident #7's record does not include the reportable incidents for the resident.

Document Submission

Reportable incidents were maintained in the residents electronic file, however, going forward all reportable incidents will be printed and placed in the residents administrative file.

Compliance will be monitored during monthly file audits, please see attached audit form

Audits will be reviewed during QMP meeting

Completion Date: 12/02/2021

Document Submission

Implemented

Reportable incidents have been printed and placed in residents files. Monthly file audits are being conducted to monitor compliance of this regulation. See attached

Completion Date: 12/06/2021

187b - Date/Time of Medication Admin.

Medications

1. Requirements

Medications (continued)

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed Lorazepam 0.5 mg every 12 hours as needed. Resident #4's November medication administration record (MAR) does not include the initials of the staff person who administered it on 10/28/21, 10/30/21, 10/31/21, and 11/09/2021 at 09:00 AM.

Repeat Violation: 01/26/2021

Document Submission

Residents lorazepam was given and documented on the narcotic log, however staff did not sign it off in the MAR. Going forward, all staff have been re-educated of ensuring all medications are properly signed for. 3rd shift med tech will audit MARs nightly to check for any unsigned mars. Nursing staff and med techs have been re-educated on the importance of signing off all medications timely. Please see attached meeting minutes and sign off. Compliance will be monitored by DHW during monthly MAR audits

Completion Date: 12/01/2021

Document Submission

Implemented

Monthly MAR audits are being conducted to monitor for compliance please see attached

Completion Date: 12/01/2021

227h - Support Plan Refuse Sign

Services

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 #6 did not sign the support plan dated 07/22/2021. The home did not make a notation regarding the resident's ability/refusal to sign.

Repeat Violation: 01/26/2021

Document Submission

All staff who participate in RASP development were trained on best practices. Please see the attached DHS documentation training PowerPoint and sign in sheet. Going forward, all residents will participate and sign his/her own RASP. DHW and ED will monitor compliance through monthly file audits. See attached file audit form

Completion Date: 11/23/2021

Document Submission

Implemented

File audits are being conducted to monitor for compliance of this regulation. See attached

Completion Date: 12/06/2021

231b - Medical Evaluation

Secured Dementia Care Units

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.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 10/05/2021; however, the resident’s medical evaluation was completed on 07/14/2021.

Repeat Violation: 01/26/2021

Document Submission

Nursing staff who participate in obtaining resident DME's have been trained in DME best practices, please see attached DHS documentation PowerPoint and training sign off. this training included timeliness of DME's Compliance will be monitored through monthly file audits and audits will be reviewed during QMP meetings

Completion Date: 11/23/2021

Document Submission

Implemented

Monthly file audits are being conducted to monitor for compliance please see attached

Completion Date: 12/06/2021

234a - Admission Support Plan

Secured Dementia Care Units

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 #6 was admitted to the SDCU on 07/17/2020. However, the resident’s initial support plan was completed on 07/22/2020.

Repeat Violation: 01/26/2021

Document Submission

Staff who participate in the completion of RASPs were trained on best practices including timeliness of RASP completion, please see the attached training power point and sign in sheet. Compliance will be monitored by DHW and ED through monthly file audits. Audits will be reviewed in QMP meetings

Completion Date: 11/23/2021

Document Submission

Implemented

Monthly file audits are being completed to monitor for compliance, see attached

Completion Date: 12/06/2021