Department of Human Services
Bureau of Human Service Licensing

March 22, 2022

, ADMINISTRATOR

RE: WILLOWBROOK PLACE
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 22659

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/08/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Human Services Licensing Supervisor

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: *WILLOWBROOK PLACE* **License #:** *22659* **License Expiration:** *01/08/2023*

Address: *150 EDELLA ROAD, CLARKS SUMMIT, PA 18411*

County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

Name: **Phone:** **Email:**

Legal Entity

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/10/1996* **Issued By:** *PALI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *41* **Waking Staff:** *31*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *12/08/2021*

Inspection Dates and Department Representative

12/08/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served:** *30*

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:** *30*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *11* **Have Physical Disability:** *0*

Inspections / Reviews

12/08/2021 - Full

Lead Inspector: **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/10/2022*

Inspections / Reviews *(continued)*

03/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/09/2022*

03/22/2022 - Document Submission

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

18 - Compliance With Laws

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 CO2 detector in the boiler room was not operational at time of inspection.

Plan of Correction ***Accept***

2600.18
• On 12/08/2021, The Maintenance Tech installed a battery-operated CO2 detector in the basement.
• On 12/08/2021, the Maintenance Tech tested the other CO2 detectors in the home, and all were operable.
• On 12/09/2021, the Executive Director In-serviced the Maintenance Tech on Regulation 2600.18.
• The Executive Director and/or designee to test the CO2 detectors in the home 3 x week for 4 weeks, then 2 x a week for 4 weeks, then weekly for 4 weeks to ensure they are operable.
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness oof any conclusions set forth in this allegation by the survey agency.

Completion Date: *12/08/2021*

Update: *03/01/2022*

Please send/Attach proof of staff training and picture of compliance. 3-1-2022 MM

Document Submission ***Implemented***

attached staff training and picture

85b - Infestation

1. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

The outside dumpster was not closed and left vulnerable to possible infestation.

Plan of Correction ***Accept***

2600.85b
• On 12/08/2021, the dumpster was closed by the cook.
• On 12/9/2021, an in-service was done with all staff by the Executive Director on 2600.85a
• The Executive Director/Designee will audit dumpster at varying times 3 x week for 4 weeks, then 2 x a week for 4 weeks, then weekly for 4 weeks to ensure they are operable.
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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85b - Infestation (continued)

Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness oof any conclusions set forth in this allegation by the survey agency.

Completion Date: *12/09/2021*

Update: *03/01/2022*

Please send/Attach proof of staff training. 3-1-2022 MM

Document Submission ***Implemented***

attached staff training

86b - Bathroom

1. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The first-floor bathroom across from room 101 and the basement bathroom across from the activities room did not have a window or any functioning exhaust fan.

Plan of Correction ***Accept***

2600.86b

• On 2-1-2022 we received the letter from the architect that we feel should meet the DHSL request.

• BDA ARCHITES response from [redacted] AIA,NCARB,LEED,AP, and VP-COO stated that the building was designed with a ducted central exhaust system served by two main fans located in the attic. Each of the referend rooms has an exhaust louver that is connected to the main fans with duct work. The design exhaust CFM for each room is noted on drawing M4.4, Exhaust Riser Diagrams. He offered his assistance if you require any additional information

Completion Date: *12/10/2021*

Document Submission ***Implemented***

no submission needed

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 1 is prescribed a PRN medication of [redacted] that was not available on the Medication cart at the time of inspection.

Plan of Correction ***Accept***

2600.185a

185a - Implement Storage Procedures (continued)

• On 12/08/2021, the nurse contacted the resident1's physician to notify that the resident has not requested either medication in 2 months, order discontinued by physician on 12/17/21.
• On 12/9/2021, Med Cart audit was completed by the Executive Director with no other issues.
• On 12/10/2021, the Executive Director in-serviced all current Nurses and Med Techs on 2600.185a
• The Executive Director/CSM/Nurse will audit 5 residents medication orders with medications to ensure mediation availability for administration 3 x week for 4 weeks, then 2 x a week for 4 weeks, then weekly for 4 weeks.
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

Update: *03/01/2022*

Please send/Attach medication discontinue order and proof of staff training.
3-1-2022. MM

Document Submission ***Implemented***

attached medication discontinue order and proof of training

224a - Preadmission Screen Form

1. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

The pre-admission screening form for Resident 2 did not indicate if the home could meet the resident's needs.

Plan of Correction ***Accept***

2600.224a
Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness oof any conclusions set forth in this allegation by the survey agency.
2600.224a
Resident 2 was evaluated by [redacted] S. CSM on 4-6-21 and determined home could meet the resident's needs. This is reflected on the resident's current assessment
• On 12/9/2021 and 12/10/2021 an audit was conducted by the Executive Director on current pre-screenings to ensure it indicted home could meet resident's needs. There were no additional issues observed during audit.
• On 12/20/2021, Our new CSM was in-serviced by the Executive Director on Regulation 2600.224a.
• The Executive Director/Designee will review pre-screenings for new admissions within 48 hours of completion for

224a - Preadmission Screen Form (continued)

completion weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure it is indicted home can meet resident's needs
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

Update: *03/01/2022*

Please send/Attach proof of resident #2's updated pre-admission screening. Also, attach proof of staff training. 3-1-2022 MM

Document Submission ***Implemented***

proof of pre-admission training

225a - Assessment 15 Days

1. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

The assessment plan for Resident 3 was completed [redacted]. Resident 3 was admitted to the home on [redacted]

Plan of Correction ***Accept***

2600.225a
• Resident 3 has a current assessment plan
• On 12/08/2021 and 12/9/2021 an audit was completed by the Executive Director on current resident RASP Assessments to ensure written initial assessment is documented within 15 days of admission. There were no additional issues observed during audit.
• On 12/09/2021, an in-service was done with the by the Executive Director with the new CSM on 2600.225a
• The Executive Director/CSM will audit 5 resident RASPS x a week for 4 weeks, then 3 RASPS x a week for 4 weeks, then 1 RASPS weekly for 4 weeks to ensure written initial assessment is documented within 15 days of admission.
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

225a - Assessment 15 Days *(continued)*

Document Submission ***Implemented***

no submission needed

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

The annual Assessment Plan for Resident 4 was completed [redacted]. The previous assessment was completed 6/16/2020.

Plan of Correction ***Accept***

2600.225c
• Resident 4 has a current annual assessment plan
• On 12/08/2021 and 12/9/2021 an audit was completed by the Executive Director on current resident RASP Assessments to ensure annual assessment plan completed timely. There were no additional issues observed during audit.
• On 12/20/2021, an in-service was done with the by the Executive Director with the new CSM on 2600.225c
• The Executive Director/CSM will audit current 5 resident RASPS x a week for 4 weeks, then 3 RASPS x a week for 4 weeks, then 1 RASPS weekly for 4 weeks to ensure annual assessment plan completed timely.
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

Document Submission ***Implemented***

no submission needed

227a - Support Plan 30 Days

1. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

The support plan for Resident 3 was completed [redacted] Resident 3 was admitted to the home on [redacted].

Plan of Correction ***Accept***

2600.227a

227a - Support Plan 30 Days (continued)

• Resident 3 has a current support plan
• On 12/08/2021 and 12/9/2021 an audit was completed by the Executive Director on current residents Support plans to ensure plan completed within 30 days of admission. There were no additional issues observed during audit.
• On 12/20/2021, an in-service was done with the by the Executive Director with the new CSM on 2600.227a
• The Executive Director/CSM will audit 5 residents support plans a week for 4 weeks, then 3 support plans x a week for 4 weeks, then 1 support weekly for 4 weeks to ensure plan completed within 30 days of admission.
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

Document Submission ***Implemented***

no submission needed

227c - Support Plan Revision

1. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

The annual support Plan for Resident 4 was completed [redacted] The previous assessment was completed [redacted]

Plan of Correction ***Accept***

2600.227c
• Resident 4 has a current support plan
• On 12/08/2021 and 12/9/2021 an audit was completed by the Executive Director on current resident Support plans to ensure annual support plan completed timely. There were no additional issues observed during audit.
• On 12/20/2021, an in-service was done with the by the Executive Director with the new CSM on 2600.227c
• The Executive Director/CSM will audit resident support plans a week for 4 weeks, then 3 support plans x a week for 4 weeks, then 1 support plan weekly for 4 weeks to ensure annual support plan completed timely
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

227c - Support Plan Revision *(continued)*

Document Submission ***Implemented***

no submisssion needed

227d - Support Plan Medical/Dental

1. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The Resident Assessment and Support Plan dated [redacted] for Resident 2 had conflicting information regarding the resident's mobility assessment. It indicated that the resident was independent and mobile as well as having moderate mobility needs and Immobile.
The Resident Assessment and Support Plan of Resident 4 dated [redacted] does not indicate that the resident is utilizing a bed cane on their bed.

Plan of Correction ***Accept***

2600.227d
• 12/09/2021, the Executive Director added an addendum for the resident 4's bed cane and corrected the mobility of resident 2 on the RASPS
• On 12/08/2021 and 12/9/2021 an audit was completed on current residents RASP and Support plans by the Executive Director to ensure documents accurately reflect current stats of residents.
There were no additional issues observed during audit.
• On 12/9/2021, an in-service was done with the RCSS by the Regional Director of Care Services on 2600.227d
• The Executive Director/CSM will audit 5 residents RASPS and support plans a week for 4 weeks, then 3 a week for 4 weeks, then 1 weekly for 4 weeks to ensure documents accurately reflect current stats of residents

• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

Update: *03/01/2022*

Please send/Attach proof of staff training regarding compliance with this regulation. 3-1-2022 MM

Document Submission ***Implemented***

proof of training

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

The Resident Assessment and Support Plan of Resident 2 dated [redacted] was not dated by the resident who participated and signed the RASP.

Plan of Correction ***Accept***

2600.227g
• On 12-09-2021 [redacted] Executive Director, reviewed the resident assessment and support plan with resident 2 and retrieved date of signature.
• On 12/08/2021 and 12/9/2021 an audit was completed by the Executive Director on current residents RASP and Support plans to ensure a date was included for date signature was obtained by resident/POA. There were no additional issues observed during audit.
• On 12/20/2021, an in-service was done with the by the Executive Director with the new CSM on 2600.227g
• The Executive Director/CSM will audit 5 resdients RASPS and support plans a week for 4 weeks, then 3 a week for 4 weeks, then 1 weekly for 4 weeks to ensure a date was included for date signature was obtained by resident/POA
• Audit results will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.
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Completion Date: *02/10/2022*

Document Submission ***Implemented***

no submission needed