Department of Human Services
Bureau of Human Service Licensing

March 7, 2022

[redacted]
STATESMAN WOODS AID OPCO LLC
2619 TRENTON ROAD
LEVITTOWN, PA, 19056

RE: WOODBOURNE PLACE
2619 TRENTON ROAD
LEVITOWN, PA, 19056
LICENSE/COC#: 13955

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/28/2022, 01/31/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Shawn Parker

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: *WOODBOURNE PLACE* **License #:** *13955* **License Expiration:** *07/11/2022*

Address: *2619 TRENTON ROAD, LEVITOWN, PA 19056*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *2159436611* **Email:** [redacted]

Legal Entity

Name: *STATESMAN WOODS AID OPCO LLC*

Address: *2619 TRENTON ROAD, LEVITTOWN, PA, 19056*

Phone: *2159436611* **Email:** [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *61* **Waking Staff:** *46*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *01/31/2022*

Inspection Dates and Department Representative

01/28/2022 - Off-[redacted]

01/31/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served:** *44*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *40*

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *17* **Have Physical Disability:** *1*

Inspections / Reviews

01/28/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/19/2022*

Inspections / Reviews *(continued)*

02/22/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/25/2022*

03/07/2022 - Document Submission

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

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

Staff member A was hired on [redacted] and their criminal background check was completed on 1/12/22.

Plan of Correction ***Accept***

Plan of Correction:
On 01/31/2022, the Executive Director (ED) in-serviced the Administrative Specialist on the requirements stated within 2600.51. (Exhibit –A1 In-Service sign in sheet)
On 02/15/2022, the ED audited current personnel files of direct care staff to validate each employee has a criminal background check completed in accordance with the Older Adult Protective Services Act. (Exhibit – A2 Audit tool)
Beginning 01/31/2022, for the duration of 60 days, the ED and/or designee will audit newly hired employee personnel files on an employee's first day of employment to validate each employee has a criminal background check completed in accordance with the Older Adult Protective Services Act. (Exhibit – A3 Audit Tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date: 02/15/22.

Document Submission ***Implemented***

• On 01/31/2022, the Executive Director (ED) in-serviced the Administrative Specialist on the requirements stated within 2600.51. (Exhibit –A1 In-Service sign in sheet)
• On 02/15/2022, the ED audited current personnel files of direct care staff to validate each employee has a criminal background check completed in accordance with the Older Adult Protective Services Act. (Exhibit – A2 Audit tool)
• Beginning 01/31/2022, for the duration of 60 days, the ED and/or designee will audit newly hired employee personnel files on an employee's first day of employment to validate each employee has a criminal background check completed in accordance with the Older Adult Protective Services Act. (Exhibit – A3 Audit Tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
• Completion Date: 02/15/22.

54a - Direct Care Staff

1. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

54a - Direct Care Staff *(continued)*

Plan of Correction ***Accept***

Plan of Correction:
The ED removed direct care staff person B from the schedule pending the receipt of their high school diploma.
On 01/31/2022, the ED in-serviced the Administrative Specialist on the requirements stated within 2600.54.a. (Exhibit - B1 In-Service sign in sheet)
On 02/15/2022, the ED audited current personnel files of direct care staff to validate each employee has at minimum a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. If applicable, Department of Human Service waivers will be validated for employees who attended educational institutions abroad. (Exhibit – B2 Audit tool)
Beginning 01/31/2022, for the duration of 60 days, the ED and/or designee will audit newly hired employee personnel files on an employee's first day of employment to validate each employee has at minimum a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. (Exhibit – B3 Audit Tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date: 02/15/2022.

Document Submission ***Implemented***

• The ED removed direct care staff person B from the schedule pending the receipt of their high school diploma.
• On 01/31/2022, the ED in-serviced the Administrative Specialist on the requirements stated within 2600.54.a. (Exhibit - B1 In-Service sign in sheet)
• On 02/15/2022, the ED audited current personnel files of direct care staff to validate each employee has at minimum a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. If applicable, Department of Human Service waivers will be validated for employees who attended educational institutions abroad. (Exhibit – B2 Audit tool)
• Beginning 01/31/2022, for the duration of 60 days, the ED and/or designee will audit newly hired employee personnel files on an employee's first day of employment to validate each employee has at minimum a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. (Exhibit – B3 Audit Tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
• Completion Date: 02/15/2022.

183b - Meds and Syringes Locked

1. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 1/31/21 at 10:30am in resident #1's room the following medications were out on the counter: Ketoconazole cream 2%, Chlorhex Glu sol 12%, and Hydrocort Lot 2.5% however resident #1 cannot self-administer medications.

Plan of Correction ***Accept***

Plan of Correction:
Resident #1 did not suffer a negative effect related to this finding.
On 01/31/2022, the ED audited current resident rooms for unsecured medications, no additional unsecured medications were noted (Exhibit – C1 audit tool).

183b - Meds and Syringes Locked (continued)

On 01/31/2022, the ED in-serviced the Care Service Manager (CSM) on the requirements stated within 2600.183.b. (Exhibit – C2 In-Service sign in sheet)
On 02/17/2022, the ED in-serviced the Medication Technicians on the requirements stated within 2600.183.b. (Exhibit –C3 In-Service sign in sheet)
The CSM and/or designee will audit 5 resident rooms weekly x 4 weeks, then bi-weekly x 4 weeks, and monthly x 1 to ensure the absence of unsecured over-the-counter medications. (Exhibit - C4Audit Tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date: 02/17/2022.

Document Submission ***Implemented***

• Resident #1 did not suffer a negative effect related to this finding.
• On 01/31/2022, the ED audited current resident rooms for unsecured medications, no additional unsecured medications were noted (Exhibit – C1 audit tool).
• On 01/31/2022, the ED in-serviced the Care Service Manager (CSM) on the requirements stated within 2600.183.b. (Exhibit – C2 In-Service sign in sheet)
• On 02/17/2022, the ED in-serviced the Medication Technicians on the requirements stated within 2600.183.b. (Exhibit –C3 In-Service sign in sheet)
• The CSM and/or designee will audit 5 resident rooms weekly x 4 weeks, then bi-weekly x 4 weeks, and monthly x 1 to ensure the absence of unsecured over-the-counter medications. (Exhibit - C4Audit Tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
• Completion Date: 02/17/2022.

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

On 1/31/22 at 12:30pm, there was 1 loose pink circular pill labelled EM2 in of med cart B.

On 1/31/22 at 12:40pm, there was 1 loose white oval pill in of med cart A.

Plan of Correction ***Accept***

Plan of Correction:
On 01/31/2022, the ED audited the homes medication carts to validate medications were stored in an organized manner. No additional loose pills were discovered. (Exhibit – D1 audit tool)
On 01/31/2022, the ED in-serviced the CSM on the requirements stated within 2600.183.e. (Exhibit – D2 In-Service sign in sheet)
On 02/17/2022, the ED in-serviced the Medication Technicians on the requirements stated within 2600.183.e. (Exhibit – D3 In-Service sign in sheet)
The CSM and/or designee will audit the homes medication carts weekly x 4 weeks, then bi-weekly for 4 weeks, then monthly x 1 to validate medications are store in an organized manner. (Exhibit – D4 Audit Tool)

183e - Storing Medications (continued)

Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date: 02/17/2022.

Document Submission ***Implemented***

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Update: *03/07/2022*

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 Adult Tussin DM SF LIQ give 10ml by mouth every 6 hours as needed. However, on 1/31/22 it was unavailable in the home.

Plan of Correction ***Accept***

Plan of Correction:
Resident #1 did not suffer a negative effect related to this finding.
On 1/28/22, at the time of the finding, the ED ordered Resident #1's Adult Tussin DM from the pharmacy. (Exhibit – E1 pharmacy order sheet)
On 02/01/2022, the ED audited the homes medication carts to validate ordered medications were accessible. No additional medications were identified as not readily accessible. (Exhibit – E2 audit tool)
On 02/01/2022, the ED in-serviced the CSM on the requirements stated within 2600.185.a. (Exhibit – E3 In-Service sign in sheet)
On 02/17/2022, the ED in-serviced the Medication Technicians on the requirements stated within 2600.185.a. (Exhibit – E4 In-Service sign in sheet)
The CSM or designee will audit the homes medication carts weekly x 4 weeks, then bi-weekly for 4 weeks, then monthly x 1 to validate ordered medications are accessible within the home. (Exhibit- E5 Audit tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date:02/01/2022.

Document Submission ***Implemented***

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187b - Date/Time of Medication Admin.

1. Requirements

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 #2's medication administration record does not include the initials of the staff person who administered their medications on 1/1/22. In an interview with resident 2, the resident stated they never went a full day without receiving their medications.

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction ***Accept***

Plan of Correction:
Resident #2 did not suffer a negative effect related to this finding.
On 01/31/22, the identified staff member documented late entries for Resident #2 on the Medication Administration Record (MAR)(Exhibit – F1 MAR, Late entries)
On 02/01/22, the CSM audited the homes MARs, no additional documentation omissions were noted. (Exhibit – F2 audit tool)
On 02/01/2022, the ED in-serviced the CSM on the requirements stated within 2600.187.b. (Exhibit – F3 In-Service sign in sheet)
On 02/17/2022, the ED in-serviced the Medication Technicians on the requirements stated within 2600.187.b. (Exhibit - F4 In-Service sign in sheet)
The CSM or designee will audit the homes MARs weekly x 4 weeks, then bi-weekly for 4 weeks, then monthly x 1 to validate the absence of documentation omissions. (Exhibit – F5 Audit tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date: 02/17/2022.

Document Submission ***Implemented***

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187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 was prescribed Doxycycline 100mg 1 capsule every 12 hours for 10 days for infection stating 1/16/22, however this medication was not administered on 1/18/22 at 8PM after being administer at 8AM on 1/18/22

Resident #1 is prescribed Ketoconazole Cre 2% Apply topically twice a day to Nasolabial Area, however it was only administered once on 1/23/22.

Resident #1 is prescribed Ketoconazole Cre 2% Apply topically to affected area(s) in the groin twice a day for 14 days starting 12/20/21. Therefore it should be completed on 1/2/22. However it was administered from 1/3/22-1/28/22.

Resident #1 is prescribed Econazole Cre 1% Apply topically to affected area of Belly twice a day, however it was only administered once on 1/19/22.

Resident #1 is prescribed Chorhex Glu Sol 1.2% rinse mouth with 15ML (1 capful) and expectorate twice a day. However, this was not administered on 1/27/22

Resident #1 is prescribed Ketoconazole Cre 2% Apply topically daily to Feet. However, it was not administered on 1/27/22.

Resident #2 is prescribed Metformin tab 500mg take one tablet by mouth twice a day. However on 1/9/22 this medication was only administered once.

187d - Follow Prescriber's Orders (continued)

Resident #2 is prescribed Escitalopram Tab 10MG take one tablet by mouth once daily. However on 1/23/22 this medication was not administered.

Plan of Correction ***Accept***

Plan of Correction:
Resident #1 or #2 did not suffer a negative effect related to this finding.
On 01/31/2022, the CSM notified Resident #1 and #2's prescribing medical providers and designated responsible parties of omitted administrations.
Resident #1 is prescribed Ketoconazole Cre 2% was extended through 01/28/2022 (Exhibit-G1 verbal order sheet)
On 02/1/2022, the CSM audited the homes MARs, no additional documentation omissions were noted. (Exhibit –F2 audit tool)
On 02/01/2022, the ED in-serviced the CSM on the requirements stated within 2600.187.d. (Exhibit – G2 In-Service sign in sheet)
On 02/17/2022, the ED in-serviced the Medication Technicians on the requirements stated within 2600.187.d. (Exhibit – G3 In-Service sign in sheet)
The CSM or designee will audit the homes Medication Administration Records weekly x 4 weeks, then bi-weekly for 4 weeks, then monthly x 1 to validate the absence of documentation omissions. (Exhibit- F5 Audit tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date: 02/01/2022.

Document Submission ***Implemented***

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2. Requirements

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

Description of Violation

Resident #1 is prescribed Fluocin Acet Sol 0.01% apply topically to affected area on posterior scalp daily at bedtime 2 days a week. However, on 1/31/22 it was unavailable in the home.

Plan of Correction ***Accept***

Plan of Correction:
Resident #1 or #2 did not suffer a negative effect related to this finding.
On 01/31/2022, the CSM notified Resident #1 and #2's prescribing medical providers and designated responsible parties of omitted administrations.
Resident #1 is prescribed Ketoconazole Cre 2% was extended through 01/28/2022 (Exhibit-G1 verbal order sheet)
On 02/1/2022, the CSM audited the homes MARs, no additional documentation omissions were noted. (Exhibit –F2 audit tool)
On 02/01/2022, the ED in-serviced the CSM on the requirements stated within 2600.187.d. (Exhibit – G2 In-Service sign in sheet)
On 02/17/2022, the ED in-serviced the Medication Technicians on the requirements stated within 2600.187.d. (Exhibit – G3 In-Service sign in sheet)
The CSM or designee will audit the homes Medication Administration Records weekly x 4 weeks, then bi-weekly for 4 weeks, then monthly x 1 to validate the absence of documentation omissions. (Exhibit- F5 Audit tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued

auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion Date: 02/01/2022.

Document Submission ***Implemented***

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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

Resident #2 was admitted on [redacted]; however, the resident's assessment was not completed until 9/2/21.

Plan of Correction ***Accept***

Plan of Correction:
Resident #2 did not suffer a negative effect related to this finding.
On 02/01/2022, the ED in-serviced the Care Services Manager (CSM) on the requirements stated within 2600.225.a. (Exhibit – H1 In-service)
On 02/03/2022, the CSM/ED conducted an audit of current Resident Assessment and Support Plans (RASPs), validating that resident's date of admission and initial assessment dates were completed within 15 days of admission. (Exhibit – H2 Audit tool)
The CSM and/or designee will audit the RASPs of new admissions weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure initial completions are done within 15 days of admission. (Exhibit- H3 Audit Tool)
Results of the audit will be discussed during Monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
Completion date: 02/03/2022.

Document Submission ***Implemented***

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