Department of Human Services
Bureau of Human Service Licensing

October 24, 2022

[redacted]
INSPIRIT MACUNGIE OPERATOR LLC
6488 ALBURTIS ROAD
MACUNGIE, PA, 18062

RE: THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY
6488 ALBURTIS ROAD
MACUNGIE, PA, 18062
LICENSE/COC#: 22681

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/01/2022 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: *THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY* **License #**: *22681* **License Expiration**: *11/07/2022*

Address: *6488 ALBURTIS ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *INSPIRIT MACUNGIE OPERATOR LLC*

Address: *6488 ALBURTIS ROAD, MACUNGIE, PA, 18062*

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *50* **Waking Staff**: *38*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *02/01/2022*

Inspection Dates and Department Representative

02/01/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *47*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*

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

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

02/01/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/18/2022*

Inspections / Reviews *(continued)*

04/18/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/25/2022*

05/11/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/18/2022*

10/24/2022 - Document Submission

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 did not receive the prescribed Admelog from [redacted]/21, the prescribed gabapentin, hydrazaline, and melatonin on [redacted]/21, the prescribed dorzolamide, eye drops, aspirin, amlodipine, pantoprazole, letrozole, and hydralazine on [redacted]/21. The Department was not notified regarding the medication errors.

Plan of Correction ***Accept***

Prior Administration----Moving forward, new Administration in-serviced staff on [redacted]/22 regarding Reg 16.c. Medication Technician will notify Resident Wellness Director or designee of missed medications. RWD or designee will notify both doctor and DHS. A fax communication of notification will be sent within 24 hours to both parties and confirmation of fax will be kept on file. See attached In service sheet.

Completion Date: *03/13/2022*

Document Submission ***Implemented***

Update: *10/24/2022*

ag, 10-24-22

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

A review of the call bell logs from [redacted]/22 indicated that residents that require assistance with their ADL's have waited 15-26 minutes until they are assisted by staff.

Plan of Correction ***Accept***

Staff has been in-serviced on this regulation to ensure compliance. See attached. We are having our mandatory monthly staff in-service on [redacted]/22 which we will remind employees of this and all violations received 2/1/22 with our POC. More staff responder pendants were ordered and issued to the nursing team. They are responsible to turn them over to the incoming shift. In the office we have a monitoring system which the BOM, RWD, and ED have been checking on a weekly basis since the surveyor was present. Currently we are answering the call bells in less than 5-8 minutes max. This will not only ensure with compliance but care for the needs of the resident in a timely manner.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

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.

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

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
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.
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

Direct care staff member A hired [redacted]/21 and ancillary staff member B hired [redacted]/21 did not receive the first day fire safety orientation.

Plan of Correction ***Accept***

This violation was previously addressed. New administration has incorporated the attached paperwork to ensure compliance with Reg. 65.a and has been utilized for all new hires since surveyor was present. All new staff will be in-serviced by our new maintenance director within the first 8 hours of orientation on day one.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

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

Direct care staff member A hired [redacted]/21 did not have training in resident rights and emergency medical plan within the first 40 hours worked. Ancillary staff member B hired [redacted]/21 did not receive training in resident rights, the Older Adult Protective Services Act, emergency medical plan and reporting of reportable incidents and conditions.

Plan of Correction ***Accept***

This violation was previously addressed. New administration has incorporated the attached paperwork to ensure compliance with Reg 65.b. All new employees will sign the attached after being in-serviced within the first 40 hours of orientation. Care staff persons A&B have been addressed at both January and February mandatory all staff meetings required by DHS.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff member C hired [redacted]/21 did not complete the department approved direct care competency course.

Plan of Correction ***Accept***

New administration will have direct care staff persons take the DHS competency test prior to training in community. Direct care staff can either take the test at home and bring a copy prior to first day orientation or we will provide a computer for the test to be taken on site. Business Office Manager will create a tickler for new staff files ensuring that the file does not go into the filing cabinet drawer until completion. [redacted] will notify staff to what is still necessary prior to staff training in community in their prospective departments. Administrator will spot check for completion.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

132a - Monthly Fire Drill

1. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home did not conduct a fire drill in January 2022.

The fire drill conducted on 12/31/21 was not unannounced. The staff member conducting the drill told the cook and the manager on duty there would be a drill.

Plan of Correction ***Accept***

New administrator in-serviced maintenance director of Reg 132.a while surveyor was still present in community. Administrator created annual fire drill sheet noting times and dates for maintenance director and explained the importance of unannounced drills to ensure staff and residents are prepared to evacuate safely and correctly. Fire safety expert,[redacted], was in community on 2/3/22 and explained the importance of this regulation to maintenance director also. Our new maintenance director also received a copy of the annual drills and was in-serviced on unannounced drills. See attached.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

132b - Safety Inspection/Fire Drill

1. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not have a supervised fire drill or fire safety inspection conducted by a fire safety expert in the last year.

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

New administration is aware of this regulation. Immediately after surveyor exited, [redacted], fire safety expert was called. [redacted] came to the community on 2/3/22 and completed a fire drill. See attached. [redacted] is schedule to come to the community in July for additional training. Administrator or designee will be responsible annually to ensure

132b - Safety Inspection/Fire Drill (continued)

compliance with this regulation moving forward.

Completion Date: *03/14/2022*

Update: *04/18/2022*

The home will secure and submit a letter or acceptable documentation from their Fire Safety Expert at the earliest opportunity.

AG, 4-18-22

Plan of Correction ***Accept***

The home will secure and submit a letter or acceptable documentation from their Fire Safety Expert at the earliest opportunity.

AG, 4-18-22 see attached letter received from FSE

Completion Date: *04/25/2022*

Update: *05/11/2022*

132b letter reviewed and accepted in Step 1, AG, 5-11-22

Document Submission ***Implemented***

132b letter reviewed and accepted in Step 1, AG, 5-11-22

132c - Fire Drill Records

1. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home does not have the required information for the fire drill conducted on 12/31/21.

Plan of Correction ***Accept***

See attached. New administration is using the DHS required paperwork and in-serviced our maintenance director of the importance of this regulation at time of survey while surveyor was present. A copy of this is also in our Tabula Pro system and will be completed monthly as drills occur and will be documented by administrator or designee.

Completion Date: *03/14/2022*

Update: *04/18/2022*

a copy of the Home's fire drill logs shall be submitted for Step 2.

AG, 4-18-22

Document Submission ***Implemented***

a copy of the Home's fire drill logs shall be submitted for Step 2.

AG, 4-18-22

132d - Evacuation

1. Requirements

132d - Evacuation *(continued)*

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

An interview with the staff member that conducted the fire drill on 12/31/21 indicated that the fire drill took approximately 15 mins for evacuation. The home does not have a current letter from a fire safety expert designating a safe evacuation time based on the physical construction of the building.

Plan of Correction ***Accept***

While surveyor was present, ED called [redacted], fire safety expert, who came to our community on 2/3/22. See attached fire drill record. At that time [redacted] was made aware of the fact that a letter was needed and verbally proposed a timeframe for evacuation. ED called several times, lastly, on 3/9,22 requesting a copy of the required DHS letter. When the letter arrives via mail, we will forward to DHS per regulation. New administrator and new maintenance director is aware of this regulation and will be responsible going forward.

Completion Date: *03/14/2022*

Update: *04/18/2022*

A copy of the letter will be submitted in Step 2 please.

AG, 4-18-22

Document Submission ***Implemented***

A copy of the letter will be submitted in Step 2 please.

AG, 4-18-22

141a 1-10 Medical Evaluation Information

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 #2's DME dated [redacted]/21 did not have anything noted for ability to self-administer medications and body positioning.

Resident #3's DME dated [redacted]/21 did not have anything noted for height, weight and body positioning.

141a 1-10 Medical Evaluation Information (continued)

Resident #4's DME dated [redacted]/21 did not have anything noted for height, and weight.

Plan of Correction ***Accept***

This violation was previously addressed prior to new administration. New Resident Wellness Director updated resident's #2,3,&4 with missing information and had Doctor [redacted] initial the changes. RWD had reviewed all resident charts for missing information and made the changes necessary to complete the form. Moving forward, RWD or designee will review for completion of all paperwork prior to going into residents chart or such chart being filed in medical office. RWD or administrator will routinely spot check for accuracy.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

141b1 - Annual Medical Evaluation

1. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #6's most recent DME was completed on [redacted]20.

Plan of Correction ***Accept***

New Resident Wellness Director has developed a tickler system after reviewing all prior resident's charts using a calendar tracking system. This will ensure all updated medical information is current and medical needs can/will be met. RWD or designee will be responsible to inform doctor in advance of annual paperwork being outdated. Resident chart will not be placed in the medical chart area until completion of all annual paperwork is current.

Completion Date: *03/14/2022*

Update: *04/18/2022*

a copy of the tracker that is IN USE shall be submitted in Step 2.

AG, 4-18-22

Document Submission ***Implemented***

a copy of the tracker that is IN USE shall be submitted in Step 2.

AG, 4-18-22

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

Resident #7's humalog and insulin pens were not dated when the pens were opened. The manufacturer's instructions read the insulin expires 28 days after opening.

Plan of Correction ***Accept***

See attached communication/in-service meeting dated 2/22/22. Medication technicians will be responsible to label

183e - Storing Medications (continued)

and date all medications when opened. They will spot check all medications they use for their residents on their shift to ensure they are labeled and dated. A cart audit will be performed weekly by RWD or designee moving forward. RWD will spot check monthly for compliance.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

186b - Medication Used by Resident

1. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

Interviews with staff members indicated that the staff were using Resident #7's insulin for Resident #1 in [redacted] 2021 because the resident did not have any.

Plan of Correction ***Accept***

Please see attached in-service. Moving forward, medication will be ordered prior to running out or when running low. Med tech or designee will fax to pharmacy for refill 3-7 days prior to running out of medication. Med carts will be viewed daily by Med Tech and weekly by RWD or designee to ensure all residents have their prescribed medications. This will ensure compliance and residents will not be receiving any else's medication.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 did not receive the prescribed Admelog from [redacted]/21, the prescribed gabapentin, hydrazaline, and melatonin on [redacted]/21, the prescribed dorzolamide, eye drops, aspirin, amlodipine, pantoprazole, letrozole, and hydralazine on [redacted]/21.

Plan of Correction ***Accept***

Please see attached in-services. Medication Technicians were in-serviced on the Quick Mar system which will allow them to scan and initial when medication is given. They will double check to ensure all residents receive medications as ordered by prescriber prior to closing out of the system. Ongoing shift will check that medication was given. Resident Wellness Director or designee will check daily to be assured that there are no highlighted areas of medications not given to the residents and they were received as ordered.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

188b - Medication Error Reporting

1. Requirements

2600.

188b - Medication Error Reporting *(continued)*

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 did not receive the prescribed Admelog from [redacted]/21, the prescribed gabapentin, hydrazaline, and melatonin on [redacted]/21, the prescribed dorzolamide, eye drops, aspirin, amlodipine, pantoprazole, letrozole, and hydralazine on [redacted]/21. The prescriber was not notified regarding the medication errors.

Plan of Correction ***Accept***

Please see attached in-service. The medication technicians were in-serviced on this regulation. We also conducted a medication training class and those who attended also received additional training from our trainer on regulation 188.b. Going forward, when a med error is noted, MT or designee will be responsible to inform Resident Wellness Director and family. MT or designee will also fax notification to doctor and DHS. A fax confirmation will be kept on file. RWD will review faxed transmission from doctor noting any changes and acknowledgements.

Completion Date: *03/14/2022*

Document Submission ***Implemented***

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 #5 was admitted to the home on [redacted]/21, the assessment portion of the RASP was not completed.

Resident #2 was admitted to the home on [redacted]/21, the assessment portion of the RASP was not completed.

Plan of Correction ***Accept***

Prior to new administration. New Resident Wellness Director reviewed all resident charts bringing all RASPS, assessments, and DME's up to date. RWD developed a tickler system to ensure compliance is met. After the assessment is completed, a copy is placed in the resident's chart as well as in a binder for staff to review to ensure resident needs are met.

Completion Date: *03/14/2022*

Update: *04/18/2022*

Please send in a copy of the tickler system that is IN USE for review in Step 2. Not a blank form please.

AG, 4-18-22

Document Submission ***Implemented***

Please send in a copy of the tickler system that is IN USE for review in Step 2. Not a blank form please.

AG, 4-18-22 Please see attached. New WD set up a binder month by month in order to establish whose DME/RASP needs updating. [redacted] notifiys the doctor in advance of due date and places DME in resident charts and RASPs in charts as well as informs staff of update.

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #6's most recent assessment portion of the RASP was completed on [redacted]/20.

Plan of Correction ***Accept***

New administration reviewed resident's charts and updated as needed. Resident Wellness Director developed a tickler system to ensure compliance going forward. RWD or designee will review charts on a regular basis to maintain system in place creates a complete profile of resident needs. Administrator will randomly review charts in order to ensure compliance with regulation 225.c

Completion Date: *03/14/2022*

Update: *04/18/2022*

Please send in a copy of the tickler system that is in use for Step 2.

AG, 4-18-22

Document Submission ***Implemented***

Please send in a copy of the tickler system that is in use for Step 2.

AG, 4-18-22 Please see DME/RASP ticker which is placed in binder going month by month.