pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: October 14, 2022

[redacted]
[redacted]
Springfield PCH, LLC
[redacted]
[redacted]

RE: Springfield Crossings
463 West Sproul Road
Springfield, Pennsylvania 19064
License #: 146511

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection February 23, 2022 and June 21 and 22, 2022 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 146510 dated November 18, 2021 to November 18, 2022 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated November 18, 2021 to November 18, 2022 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 14, 2022 to April 14, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

[redacted]

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Jeanne Parisi, Bureau Director
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *SPRINGFIELD CROSSINGS* **License #:** *14651* **License Expiration:** *11/18/2022*

Address: *463 WEST SPROUL ROAD, SPRINGFIELD, PA 19064*

County: *DELAWARE* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *6105430700* **Email:** [redacted]

Legal Entity

Name: *SPRINGFIELD PCH LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *02/10/2000* **Issued By:** *PA Dept of L & I*

Staffing Hours

Resident Support Staff: *87* **Total Daily Staff:** *161* **Waking Staff:** *121*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *02/23/2022*

Inspection Dates and Department Representative

02/23/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served:** *62*

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:** *62*

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

Have Mobility Need: *12* **Have Physical Disability:** *2*

Inspections / Reviews

02/23/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/17/2022*

03/18/2022 - POC Submission

Inspections / Reviews *(continued)*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/23/2022*

05/26/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/19/2022*

06/23/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type**: *Exception* **Follow-Up Date**:

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 2/23/2022 the home's most recent Licensing Inspection Summary, dated 6/17/2021, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept***

Copy of 6/17/2021 is now available at front desk for residents to review. Concierge will ensure that copy of most recent inspections are available at all times.

Completion Date: 02/24/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

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

On [redacted]/2021, Resident #1 was not administered the prescribed oxycodone because eight of the pills were reported missing. The home did not report this incident to the Department until [redacted]/2021.

Plan of Correction ***Directed***

As was explained to the inspection team on 2/23/22, the incident in question was discovered during the narcotics count on [redacted]/21. Upon discovery of the missing narcotics team members performing the count immediately contacted their supervisor who then contacted the administrator. The Administrator then reported the incident to the department on [redacted]21 within 24 hours of the discovery of the incident. Our current procedures identified this issue, team member followed procedures which alerted proper management team who in turn reported to the department. Resident #1 had an ample supply of medications and was able to receive [redacted]medications upon request. The community replaced resident medications.

Directed plan 4/13/22 (slw)
1. The administrator or designee will conduct a training to all direct care staff on the importance of submitting an initial incident report when they find any reportable incident within 24 hours to the Department by May 1, 2022. Sign in sheets of the completed training will be maintained for the Departments review.
2. The administrator or designee will conduct a training to all ancillary staff on the importance of submitting an initial incident report when they find any reportable incident within 24 hours to the Department by May 5, 2022. Sign in sheets of the completed training will be maintained for the Departments review.
3. The administrator or designee will review all initial incidents submitted by staff, and if additional information is needed, will follow up with the Department on the required form on the next day they are in the office, starting immediately.
4. The administrator or designee will discuss the importance of submitting initial incident reports to the Department at each monthly staff meeting for the next six (6) months, starting immediately. Documentation of the agenda will be maintained for the Departments review.

Completion Date: *02/23/2022* ***Licensee Proposed Date*** ***SW 7/21/22 Implemented***

24 - Personal Hygiene

1. Requirements

2600.
24. Personal Hygiene - A home shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

Description of Violation

The assessment and support plan, dated [redacted]/2021, for resident #2 indicates the resident requires assistance with bathing and assistance with showers.. The residents shower schedule is two showers each week. During the week of [redacted] 2022 the resident did not receive shower assistance on any days and during the weeks of [redacted], [redacted] and [redacted], 2022 , the resident was only showered once each week.

Plan of Correction ***Accept***

Resident #2 prefers to take one shower per week, [redacted] is offered two and on the day that [redacted] choses to take [redacted] shower [redacted] is given [redacted] shower. If the resident refuses [redacted] shower, team provides adl care to ensure that resident is cleaned and well groomed. Team members are instructed that if resident refuses second shower in one week they are to call Director or Wellness and resident family as they will help encourage resident to take shower. Resident family is also aware of resident's shower schedule and calls resident day before scheduled shower to remind [redacted] to take shower. This plan will be ongoing and have no end date. Resident is aware [redacted] can discuss [redacted] shower times with the Director of Wellness if [redacted] would like to change them.

Completion Date: *02/28/2022* ***Licensee Proposed Date*** ***SW 7/21/22 NOT IMPLMENTED***

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident #2 reported [redacted] did not refuse to participate in the development of the RASP on [redacted]/2021 even though [redacted] is able to make decision independently. The home created the RASP without offering the resident the ability to participant in its development.

Resident #3 reported [redacted] did not refuse or was unavailable to participate in the development of the RASP dated [redacted]/2021 even though [redacted] are very active and available. The home created the RASP without offering the resident the ability to participant in its development.

Plan of Correction ***Directed***

RASP will be reviewed at monthly QMRP meeting. RASPs due for completion each month will be reviewed by the team to ensure residents were given opportunity to sign and participate in development of their RASP.

Resident #2 & #3 were given opportunity to sign and have copies of their RASP, they did not ask to update their RASP, this was completed by 3/4/22.

Directed plan 4/13/22 (slw)
1. The administrator will conduct a training to all clinical staff on the importance of attempting more than once to obtain a residents signature or participation in the development of the RASP, by May 5, 2022.
2. The administrator or designee will conduct random interviews with residents on a monthly basis to determine if their needs are being met as indicated in the RASP, starting immediately.
4. The administrator or designee will conduct an audit of all resident RASP by May 15, 2022 to ensure all residents

42c - Treatment of Residents (continued)

were provided the opportunity to participate in the development of their RASP and sign.

3. The ED will discuss treating residents with dignity and respect at monthly staff meetings for the next six months. Documentation of the staff meeting agenda will me maintained for the Departments review.

Completion Date: *03/04/2022* ***Licensee Proposed Date*** ***SW 7/21/22*** ***Not Implemented***

86a - Ventilation

1. Requirements

2600.

86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

The resident rooms 106, 211, 219, 215, and 314 did not have operable ventilation in their bathrooms. These rooms do not have an operable window, fan, air conditioner or other mechanical ventilation to ensure airflow.

The common areas and hallways of the 2nd and 3rd floors do not have fresh airflow due to the inoperable HVAC unit that has not been repaired since 10/13/2021.

Plan of Correction ***Directed***

HVAC unit is scheduled for delivery on 3/30/22. In the interim the 2nd and 3rd floor hallways airflow has not been affected by the HVAC system. The fan systems in the building along with individual units in each room on each floor have been sufficient to allow for fresh air on both floors.

Directed plan 4/13/22 (slw)

1. *The Maintenance director will conduct monthly inspections of all HVAC units and resident bathroom fans, starting immediately.*
2. *The administrator or designee will contact the Department should the home experience a loss of HVAC units, within 24 hours on the incident report form.*
3. *The administrator will conduct random inspections of HVAC units, at least quarterly, starting immediately.*
4. *The administrator will provide verification of the delivery of the HVAC unit by May 5, 2022.*

Completion Date: *03/30/2022* ***Licensee Proposed Date*** ***SW 7/21/22 NOT IMPLEMENTED***

91 - Telephone Numbers

1. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in rooms 106, 211, and 314.

Plan of Correction ***Accept***

Emergency numbers have been posted in residents rooms.

Team members will be re-educated to check for emergency numbers when in resident rooms and replace immediately if missing.

91 - Telephone Numbers (continued)

Maintenance Director and Executive Director will randomly inspect resident rooms to ensure compliance.

Completion Date: *02/28/2022* ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The HVAC unit of the home has been inoperable since 10/13/21. The home was issued an ordinance violation and as of 2/23/2022 the system still has not been repaired.

Plan of Correction ***Directed***

HVAC system is scheduled for delivery on 3/30/22. The community has been using alternative areas of the community for daily programming since the second and third floor activities rooms cannot be used.

Directed plan 4/13/22 (slw)

1. The Maintenance director will conduct monthly inspections of all HVAC units and resident bathroom fans, starting immediately.

2. The administrator or designee will contact the Department should the home experience a loss of HVAC units, within 24 hours on the incident report form.

3. The administrator will conduct random inspections of HVAC units, at least quarterly, starting immediately.

4, The administrator will provide verification of the delivery of the HVAC unit by May 5, 2022.

Completion Date: *03/30/2022* ***licensee Proposed Date*** ***SW 7/21/22 NOT IMPLEMENTED***

107d - Procedure Emergency Management Agency Submission

1. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since there was a sale in the legal entity.

Plan of Correction ***Directed***

A copy of our entire emergency operations manual was given to our local agency. Local agency sent our cooperate contact an email confirmation on 2/23/22

Directed plan 4/13/22 (slw)

1. The administrator will review the emergency procedures to all staff, upon hire and on an annual basis, starting immediately.

2. The administrator or designee will review the emergency procedures on an annual basis and report any changes to the local emergency management agency, starting in 2023.

107d - Procedure Emergency Management Agency Submission *(continued)*

Completion Date: 03/04/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

21a - Unobstructed Egress

1. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 2/23/2022 at approximately 3:00pm the 2nd floor stairwell was locked, with a key pad, blocking egress from the home's 2nd floor. There are no directions to operate the key pad noted to allow residents to use this door to exit the home in an emergency.

Plan of Correction ***Directed***

The key pad locks were physically disabled by our regional maintenance director on 2/24/22. There is no plan by the community to re-engage these locks. The only person that would be able to re-engage these locks would be a certified locksmith. The doors now function freely like normal doors, there is nothing hindering them.

Directed plan 4/13/22 (slw)
1. The Maintenance director will conduct monthly inspections of all exit doors to ensure all doors can be opened easily by the residents, starting immediately.
2. The administrator will conduct random inspections of all exit doors, at least on a quarterly basis, to ensure all doors can be opened easily by the residents, starting immediately. **Completion Date:** *02/24/2022*

Completion Date: 03/04/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

121b - Locking Device Approval

1. Requirements

2600.
121.b. Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the home has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Description of Violation

The door at the 2nd floor stairwell, which is used as an egress route from the 2nd floor to the 1st floor was equipped with a key locking device, preventing immediately egress from the 2nd floor. The home does not have written approval or a variance from the Department of Labor and Industry, the Department of Health or the local building authority for use of the keypad.

Plan of Correction ***Accept***

Regional Maintenance Director disabled key pad locks on 2/24/22. Locks will not be reengaged.
Completion Date: *02/24/2022*

121b - Locking Device Approval *(continued)*

Completion Date: 03/04/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

123b - Emergency Procedures Posted

1. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept***

Copy of Emergency Management Plan is now available at the front desk. Concierge will ensure each day that Emergency Management plan is available for anyone that would like to review it.

Completion Date: 02/28/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

127a - Portable Space Heaters

1. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

According to the administrator, [redacted] the home has been using portable heaters in the common areas of the home since the HVAC unit has not been operational on the 2nd and 3rd floors since 10/13/2021 throughout the winter months on cold days.

Plan of Correction ***Accept***

Portable heating devices have been removed from the common area rooms affected by the HVAC system. There are alternative common areas that the residents can utilize that are serviced by a different HVAC unit.

Completion Date: 02/24/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

141a - Medical Evaluation

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.

Description of Violation

Resident #2's medical evaluation, indicating it was a change of condition, did not have a date to indicate the date the evaluation was conducted by a physician, physician's assistant or certified registered nurse practitioner.

Residents #4, #5, and #6 did not have an initial medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department.

Plan of Correction ***Accept***

Director of Wellness is working with current community residents to get new DME's for all residents. Current

141a - Medical Evaluation (continued)

resident PCP that visit community want to do no more than 5 DME per week. Target date for completion is 4/15/22.

Director of Wellness will review new admission DME prior to resident admission to ensure completion, resident DME must meet DHS guidelines for admission before resident can be admitted to the community.

Director of Wellness and Admissions Director will ensure that paper copies of DME are uploaded to residents EHR.

Completion Date: 04/15/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

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, admitted on [redacted]/2021 record did not include an initial medical evaluation.

Plan of Correction ***Accept***

Director of Wellness is working with current community residents to get new DME's for all residents. Current resident PCP that visit community want to do no more than 5 DME per week. Target date for completion is 4/15/22.

Director of Wellness will review new admission DME prior to resident admission to ensure completion, resident DME must meet DHS guidelines for admission before resident can be admitted to the community.

Director of Wellness and Admissions Director will ensure that paper copies of DME are uploaded to residents EHR.

Completion Date: 04/15/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Not*** ***Implemented***

141b1 - Annual Medical Evaluation

1. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident #4'was admitted on [redacted]/2020. The residents record does not include a medical evaluation for 2021.

Resident #6 was admitted on [redacted]/2014. The residents record does not include a medical evaluation for 2021.

Resident #11 was admitted on [redacted]/2015. The residents most recent medical evaluation is dated 10/21/2020.

Plan of Correction ***Accept***

Director of Wellness is working with current community residents to get new DME's for all residents. Current resident PCP that visit community want to do no more than 5 DME per week. Target date for completion is 4/15/22.

Director of Wellness will review new admission DME prior to resident admission to ensure completion, resident DME must meet DHS guidelines for admission before resident can be admitted to the community.

Director of Wellness and Admissions Director will ensure that paper copies of DME are uploaded to residents EHR.

Completion Date: 04/15/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

182b - Prescription Medication

1. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On [redacted], [redacted], [redacted] [redacted], and [redacted]/2022 staff person D administered medications to residents. Staff person D is not certified to pass medications. The staff was last trained on [redacted]/2020.

Plan of Correction ***Accept***

Med Tech binder will be reviewed quarterly by DOW/designee. If team members are coming due for training in next quarter Med Tech trainer will be scheduled.

Med Tech D, took department approved training by Med Tech Trainer.

Completion Date: 03/01/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current *(continued)*

Description of Violation

On [redacted]/2021 Lidocaine ointment, prescribed for individual #7, was in the home's medication cart; however, the medication was discontinued on [redacted]/2021.

On [redacted]/2021 Diclofenac Sodium,, prescribed for individual #8, was in the home's medication cart; however, the medication was discontinued on [redacted]/2021.

On [redacted]/2021 OTC Nasal Spray, prescribed for individual #9, was in the home's medication cart; however, the medication was discontinued on [redacted]/2021.

Plan of Correction ***Accept***

Community went onto cycle refill with the pharmacy which requires team to audit carts at minimum monthly to ensure all medications are current in cart. In addition Med Techs are to audit their assigned carts against the MAR to ensure that all medications prescribed are present. Any medications missing are to be reported to the nurse immediately. Director of Wellness or designee are to perform routine audits of the med carts to ensure compliance. Meaning one cart check per week to ensure by end of month all four carts have been checked.

Completion Date: *02/28/2022* ***Licensee Proposed Date*** ***SW 7/21/22 Not Implemented***

185b - Medication Procedures

1. Requirements

2600.
185.b. At a minimum, the procedures must include:

Description of Violation

Resident #10 is prescribed Acetaminophen Tab 325mg PRN every 6 hours and PRN Budesonide Suspension 0.5 mg/2ml. However, these medication were not available for administration to the resident on 2/23/2022 at 3pm.

Plan of Correction ***Accept***

Medications were delivered to community and placed in medication cart on 2/23/22 upon receipt from pharmacy that evening.

DOW or designee will perform routine audits of medication cart to ensure all medications prescribed to resident are available on the cart.

Completion Date: *02/23/2022* ***Licensee Proposed Date*** ***SW 7/21/22 Not Implemented***

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.

224a - Preadmission Screen Form *(continued)*

Description of Violation

Resident #2 was admitted to the home on [redacted]/2021; however, the president' preadmission screening form was not completed.

Resident #4 was admitted to the home on [redacted]/2020; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept***

The Director of Wellness will review all admission documents prior to admission to ensure compliance with DHS guidelines. Resident will not be admitted of department required paperwork is not present. Each month during QMRP meeting new admission file will be reviewed by team to ensure that all required documents are present.

Completion Date: 03/01/2022 ***Licensee Proposed Date*** ***SW 7/21/22*** ***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 #2 was admitted on [redacted]/2021; however, the resident's assessment was not completed until [redacted]2021.

Resident #4 was admitted on [redacted]2020; however, the resident's assessment is undated and incomplete.

Plan of Correction ***Directed***

During monthly QMRP meeting team will review residents due for monthly RASP to ensure that completion dates are met. Team will also ensure that RASP are scanned and uploaded to EHR.

Directed plan 4/13/22 (slw)
1. The administrator or designee will audit all resident RASP's to ensure all resident needs and services are documented by May15, 2022.
2. The Director of Nursing will create an audit tool to ensure all RASP's are completed annually, by May 1, 2022.
3. The administrator or designee will review all new resident assessments within 15, and the support plan portion of the RASP at 30 days to ensure the RASP is completed timely, starting immediately.
4. The administrator will review the auditing tool at the QMRP meeting, starting immediately, to ensure the RASP's are completed timely.

Completion Date: ***03/01/2022*** ***Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

225c - Additional Assessment

1. Requirements

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

225c - Additional Assessment *(continued)*

1. Annually.

Description of Violation

Resident #1's most recent assessment was completed on [redacted]/2019.

Resident #5's most recent assessment was undated.

Resident #11's most recent assessment was completed on [redacted]/2020.

Plan of Correction ***Directed***

Review to ensure monthly RASP are complete will be conducted by QMRP team at monthly meeting. Team will ensure that all RASP due that month are finished.

Resident #1, 5, 11 RASP will be updated by 3/31/22.

Directed plan 4/13/22 (slw)
The Director of nursing will updated resident #1, #5 and #11's RASP by 3/31/22.
1. The administrator or designee will audit all resident RASP's to ensure all resident needs and services are documented by May15, 2022.
2. The Director of Nursing will create an audit tool to ensure all RASP's are completed annually, by May 1, 2022.
3. The administrator or designee will review all new resident assessments within 15, and the support plan portion of the RASP at 30 days to ensure the RASP is completed timely, starting immediately.
4. The administrator will review the auditing tool at the QMRP meeting, starting immediately, to ensure the RASP's are completed timely.

Completion Date: ***03/31/2022 Licensee Proposed Date*** ***SW 7/21/22*** ***Implemented***

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

Resident #2 was admitted on [redacted]/2021; however, the resident's initial support plan was not completed until [redacted]/2021.

Resident #4 was admitted on [redacted]/2020; however, the resident's support plan was undated and incomplete.

Resident #5 was admitted to the home on [redacted]2021; however, the residents support plan dated [redacted]/2021 was incomplete and did not include dietary need.

Plan of Correction ***Directed***

RASP audits will be completed by QMRP team during monthly meeting to ensure that RASP due each month are completed to department standards.

Directed plan 4/13/22 (slw)

227a - Support Plan 30 Days (continued)

1. The administrator or designee will audit all resident RASP's to ensure all resident needs and services are documented by May15, 2022.

2. The Director of Nursing will update residents' #4 and #5 RASP to ensure their RASP's are complete and up to date, by May 5, 2022.

3. The Director of Nursing will create an audit tool to ensure all RASP's are completed annually, by May 1, 2022.

4. The administrator or designee will review all new resident assessments within 15, and the support plan portion of the RASP at 30 days to ensure the RASP is completed timely, starting immediately.

5. The administrator will review the auditing tool at the QMRP meeting, starting immediately, to ensure the RASP's are completed timely.

Completion Date: *03/01/2022* *Licensee Proposed Date* ***SW 7/21/22*** ***Implemented***

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 assessment for resident #2, dated [redacted]/2021, indicates the resident has a need for a bed enabler. The resident's support plan, dated [redacted] 2021 does not document how this need will be met.

Plan of Correction ***Directed***

Support plan was updated on 3/17/22 see initial completion date

Directed plan 4/13/22 (slw)

1. Resident #2's RASP will be updated to include the residents need for a bed enabler.

2. The Director of nursing will conduct an audit of all RASP's, by 5/15/22, to ensure all resident needs and support is noted in the RASP.

3. The Director of Nursing will create an audit tool to ensure all RASP's are completed annually, by May 1, 2022.

4. The administrator or designee will review all new resident assessments within 15, and the support plan portion of the RASP at 30 days to ensure the RASP is completed in full and timely, starting immediately.

5. The administrator will review the auditing tool at the QMRP meeting, starting immediately, to ensure the RASP's are completed timely.

Completion Date: *03/17/2022* *Licensee Proposed Date* ***SW 7/21/22*** ***Implemented***

227f - Resident Participation

1. Requirements

2600.
227.f. A resident may participate in the development and implementation of the support plan. A resident may include a designated person in making decisions about services.

227f - Resident Participation *(continued)*

Description of Violation

Resident #2 and Resident #3 were not offered the opportunity to participate in the development of their support plans dated [redacted]/2021 and [redacted]/2021 respectively.

Plan of Correction ***Directed***

See initial completion date of 3/17/22 on initial submission.

Directed plan 4/13/22 (slw)

1. Resident #2 and #3 will be offered the opportunity to participate in the development of their RASP to ensure their needs are accurately noted in the RASP and to be signed by these residents by 3/31/22.
2. The Director of nursing will conduct an audit of all RASP's, by 5/15/22, to ensure all resident needs and support are noted and have the opportunity to participate in the development of the RASP.
3. The Director of Nursing will create an audit tool to ensure all RASP's are completed annually, signed and opportunity to participate, by May 1, 2022.
4. The administrator or designee will review all new resident assessments within 15, and the support plan portion of the RASP at 30 days to ensure the resident was provided the opportunity to participate in the development of the RASP and it is completed in full and timely, starting immediately.
5. The administrator will review the auditing tool at the QMRP meeting, starting immediately, to ensure the RASP's are completed timely.

Completion Date: ***03/17/2022 Licensee Proposed Date*** ***SW 7/21/22 Implemented***

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

Resident #5 was admitted to the home on [redacted]/2021; however, the residents support plan dated [redacted]/2021 was not signed by the person who developed the support plan or the resident.

Plan of Correction ***Directed***

At the time of inspection we showed the inspection team how the team member must sign the document to close the document. Again until the department will accept e-signatures as an acceptable way to sign a document we will print a paper copy and sign it.

Directed plan 4/13/22 (slw)
1. The Director of Nursing will conduct a training to the clinical staff on how to effectively document their e-signature on the RASP, by May 5, 2022.
2. The Director of Nursing will conduct an audit of all RASP's to ensure the electronic version reflects all e-signatures, starting immediately.

227g -Support Plan Signatures (continued)

3. The administrator or designee will conduct a bi-annual audit of all electronic RASP's to ensure all required electronic signatures are reviewable, starting immediately. If the electronic version does not reflect or have the ability reflect all required e-signatures, the administrator will work with the programming company to ensure the RASP can reflect all required e-signatures, starting immediately.

Completion Date: 03/04/2022 Licensee Proposed Date ***SW 7/21/22*** ***Implemented***

227h - Support Plan Refuse Sign

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

The resident #4 did not sign the support plan. The home did not make a notation regarding the resident's refusal or inability to sign.

The resident #5 did not sign the support plan. The home did not make a notation regarding the resident's refusal or inability to sign.

Plan of Correction ***Directed***

During monthly QMRP meeting RASPs that are to be completed that month will be reviewed to ensure that residents signed them and were given the opportunity to participate in their development.

Directed plan 4/13/22 (slw)

1. The Director of Nursing or designee will meet with residents #4 and #5 to review the RASP and offer them the opportunity to sign the current RASP, by May 1, 2022.
2. The Director of Nursing will conduct a training to all clinical staff on the importance of offering the residents the opportunity to participate and sign their RASP and steps to take to attempt to obtain a signature by May 5, 2022. Documentation of the training will be maintained for the Departments review.
3. The Director of nursing will conduct an audit of all RASP's, by 5/15/22, to ensure all resident needs and support are noted and have the opportunity to participate in the development of the RASP.
4. The Director of Nursing will create an audit tool to ensure all RASP's are completed annually, signed and opportunity to participate, by May 1, 2022.
5. The administrator or designee will review all new resident assessments within 15, and the support plan portion of the RASP at 30 days to ensure the resident was provided the opportunity to participate in the development of the RASP and ensure the resident signed the RASP or their were attempts to obtain a residents signature noted, starting immediately.
5. The administrator will review the auditing tool at the QMRP meeting, starting immediately, to ensure the RASP's are completed in full, signed and completed timely.

Completion Date: ***03/01/2022 Licensee Proposed Date*** ***SW 7/21/22 Implemented***

227j - Support Plan Copy

1. Requirements

2600.
227.j. The home shall give a copy of the support plan to the resident and the resident's designated person upon request.

Description of Violation

On 2/23/2022, resident #2 and #3 reported they never saw or were offered a copy of their Support Plan.

Plan of Correction ***Directed***

See original completion date on original submission resident number 2 & 3 were given copies on that date.

RASP due that month will be reviewed at monthly QMRP team meeting to ensure residents have signed RASP and participated in their development.

Directed plan 4/13/22 (slw)

1. Resident #2 and #3 were given copies of their RASP on 2/23/22.
2. All residents will be offered the opportunity to sign and receive a copy of their RASP, if resident refuses to sign their RASP a progress note will be written by the team member reviewing the RASP with the resident.
3. The Director of nursing will conduct an audit of all RASP's, by 5/15/22, to ensure all resident needs and support are noted and have received a copy of the RASP.
4. The administrator will review the auditing tool at the QMRP meeting, starting immediately, to ensure the RASP's are completed in full, signed, given a copy of the RASP and completed timely.

Completion Date: ***03/01/2022*** ***Licensee Proposed Date*** ***SW 7/21/22*** **Implemented**

252 - Record Content

1. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #2's record does not include the prescreen form and initial assessment.

Resident #4's record does not include the prescreen form and current medical evaluation.

Resident #6's record does ot include a current medical evaluation.
Resident #6;s record does not include the current medical evaluation.

Plan of Correction ***Directed***

Team is in the process of uploading paper files to EHR, this is a slow process and will be completed by 5/31/22.

252 - Record Content (continued)

There is a team of individuals working on this. In the meantime resident paper records are stored safely and EHR is maintained in PCC. After all paper files are uploaded into EHR, we will no longer use paper files.

Directed plan 4/13/22 (slw)
1. During the upload, the Director of Nursing, will ensure residents #2's and #4 record will include their prescreen and initial assessment; resident #4's record will include the prescreen and medical evaluation, and resident #6 record will include the medical evaluation by 5/31/22.
2. The team will conduct an audit of all resident records to ensure the electronic record includes all required documents noted in this regulation, by the completion of the upload on 5/31/22.
3. The administrator or designee will audit random electronic records, at least bi-annually, to ensure all resident records include the required documentation of the regulation, starting immediately.

Completion Date: ***05/31/2022*** ***Licensee Proposed Date*** ***SW 7/21/22*** **Implemented**

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 12/25/2021 Resident #1 was unable to receive [redacted] prescribed medication oxycodone because eight of the pills were stolen. This incident was observed by staff person A. However, this allegation of abuse was not reported to the Department of Aging.

Plan of Correction ***Directed***

I ask that this violation please be reviewed. Based on conversations I have had with [redacted], I ask that this please be reviewed.

Directed 4/13/22 (slw)
1. The administrator or designee will conduct a training on the defination of abuse by May 1, 2022 as indicated in the regulations:
** The infliction of injury on a resident by staff or other residents*
• Unreasonable confinement
• Intimidation or punishment with resulting physical harm
• Deliberately causing pain or mental anguish
• Deprivation by the personal care home or its staff persons of goods or services which are necessary to maintain physical or mental health
• Sexual harassment, rape, or abuse, as defined in 23 Pa.C.C. Chapter 61 (relating to protection from abuse)
• Exploitation by an act or course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other benefit, gain of profit for the perpetrator, or monetary or personal loss

15a - Resident Abuse Report (continued)

to the resident

• Neglect of the resident, which results in physical harm, pain or mental anguish

• Abandonment or desertion by the personal care home or its staff persons

• Mistreatment or discipline of any kind

• Any sexual contact, regardless of consent, between a resident and a staff person.

2. The administrator or designee will submit any allegation of abuse to the Department within 24 hours and immediately to the Department on Aging, with the ACT 13 form completed.

3. The administrator will report the incidents when the incident is discovered in accordance with the regulations as indicated in step #2 of this plan of correction.

4. The administrator or designee will review all incident reports on a quarterly basis to ensure all incidents of alleged abuse have been reported.

Completion Date: *03/30/2022* *Licensee Proposed Date* ***SW 7/21/22 Implemented***

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/2021, for resident #2 was not signed by the resident who is capable and able to sign the contract independently.

The resident home contract dated [redacted]/2021, for resident #5, was not signed by the resident who is capable and able to sign the contract independently.

Plan of Correction ***Directed***

Resident #2 and #5 were given the opportunity to sign/date their contract by 3/31/22.

The Admission Director will make the initial attempt to get the resident and responsible party signature. If the resident or responsible party refuse to sign, the Executive Director will attempt to get the them to sign if they refuse to sign again, proper documentation will be made.

Directed plan 4/13/22 (slw)

1. The administrator of designee will conduct an audit of all resident contracts, by May 15, 2022, to ensure all contracts are signed by the residents or indicate attempts made to obtain signatures.

2. The administrator will conduct a training to the Marketing and Admission directors on the importance of obtaining resident signatures, regardless if there is a POA, unless the resident has a guardian, by May 5, 2022. The training must also include how to obtain resident signatures and how to document the attempts made to obtain the signatures.

3. The administrator will review all newly admitted resident contracts within 24 hours of admission, to ensure resident signatures were obtained, starting immediately.

Completion Date: *03/01/2022* *Licensee Proposed Date* ***SW 7/21/22 Not Implemented***