Department of Human Services
Bureau of Human Service Licensing

April 13, 2022

[redacted]
DRESHER CARE GROUP LLC
[redacted]

RE: WOODLAND CREEK ALZHEIMER'S
SPECIAL CARE CENTER
1424 DRESHERTOWN ROAD
DRESHER, PA, 19025
LICENSE/COC#: 14605

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/17/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER* **License #**: *14605* **License Expiration**: *04/27/2023*

Address: *1424 DRESHERTOWN ROAD, DRESHER, PA 19025*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *2156463231* **Email**: [redacted]

Legal Entity

Name: *DRESHER CARE GROUP LLC*

Address: [redacted]

Phone: *2156463231* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/19/2019* **Issued By**: *Township of Upper Dublin*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/17/2022*

Inspection Dates and Department Representative

03/17/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *33*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Facility* **Capacity**: *66* **Residents Served**: *33*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *33*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *33*

Have Physical Disability: *0*

Inspections / Reviews

03/17/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/08/2022*

Inspections / Reviews *(continued)*

04/08/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/18/2022*

04/13/2022 - Document Submission

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

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]/22 at approximately [redacted]pm, staff member A heard resident #1 yelling "stop, stop and help me". Staff member A came out of the kitchen to the dining room and observed staff member B grabbing both of resident #1's wrists tightly. Staff member A told staff member B to let the resident go. Staff member B stated that the resident became agitated when [redacted] tried to take the resident's plate away, fearing the resident would hurt [redacted] or another resident with the plate. Staff member B held the resident's wrists to get the resident to let go of the plate. Resident #1 sustained a small 1/2 mm asymmetrical tear to the inside of the left wrist.

Plan of Correction ***Accept***

All staff have been reeducated on abuse, abuse reporting, restraints, and OAPSA on 3/18/2022. (See attached in-service sheet)
Staff member in question has been terminated as of 3/17/2022
Staff will attend yearly abuse training
Training requirements will be reviewed at quarterly QA meetings

Completion Date: *03/18/2022*

Document Submission ***Implemented***

second submission of documents

42p - Restraints

1. Requirements

2600.
42.p. A resident shall be free from restraints.

Description of Violation

On [redacted]/22 at approximately [redacted]pm, staff member B attempted to remove a plate from resident #1 by grabbing and holding both of the resident's wrists, preventing the resident from moving freely.

Plan of Correction ***Accept***

All staff have been reeducated on abuse, abuse reporting, restraints, and OAPSA on 3/18/2022. (See attached in-service sheet)
Staff member in question has been terminated as of [redacted]/2022
Staff will attend yearly abuse training
Training requirements will be reviewed at quarterly QA meetings
Completion Date: *03/18/2022*

Document Submission ***Implemented***

second submission of documents

65b - Rights/Abuse 40 Hours

1. Requirements

2600.

65b - Rights/Abuse 40 Hours *(continued)*

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

Staff person A completed [redacted] 40th scheduled work hour on [redacted]/21. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Staff person B completed [redacted] 40th scheduled work hour on [redacted]/21. However, this staff person did not complete training in the following topics: emergency medical plan, reporting of reportable incidents and conditions.

Plan of Correction ***Accept***

Community under new management
New management will complete 100% audit of all employee files by 3/31/2022
Staff missing any training component will immediately be trained on missing information
Staff person A has completed training (see attached)
Staff person B has been terminated
Staff training plan will be updated yearly, and staff will complete signed in-service sheets to ensure compliance.
A 10% audit will be done monthly by Business Office Manager
Audits will be reviewed by ED at quarterly QA meetings

Completion Date: *04/15/2022*

Document Submission ***Implemented***

second submission of documents

65c - Ancillary Staff Orientation

1. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person A, whose first day of work was [redacted]/21, did not have a general orientation to [redacted] specific job functions.

Plan of Correction ***Accept***

Community under new management
New management will do 100% audit of all employee files by 3/31/2022
Staff missing any training component will immediately be trained on missing information
Staff person A was a rehired staff member after separation from employment by previous administration.
Staff person A has received all orientation upon rehire on [redacted]22 (see attached)
Staff training plan will be updated yearly, and staff will complete signed in-service sheets to ensure compliance.
a 10 % Audit will be done monthly by Business office manager

65c - Ancillary Staff Orientation (continued)

Audits will be reviewed by ED at quarterly QA meetings

Completion Date: *04/15/2022*

Document Submission ***Implemented***

second submission of documents

162e - Menu Changes

1. Requirements

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 03/17/22, French Toast with Sausage Patties were listed on the menu for the breakfast meal. Waffles with pork roll was served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept***

Menu was immediately updated with substitution for meal

Kitchen Staff have been educated on above regulation (see attached)

Substitutions will be immediately posted when necessary

ED/manager on duty will monitor menu daily for compliance

Menus will be reviewed for compliance and nutrition at quarterly QA meetings

Completion Date: *03/18/2022*

Document Submission ***Implemented***

second submission of documents

202 - Prohibitions

1. Requirements

2600.

202. The following procedures are prohibited:

6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On [redacted]22 at approximately [redacted]pm, Staff member B held both of resident #1's wrists tightly in an attempt to get the resident to let go of a plate.

Plan of Correction ***Accept***

All staff have been re educated on abuse, abuse reporting, restraints, and OAPSA on 3/18/2022. (see attached in-service sheet)

Staff member in question has been terminated as of [redacted]/2022

Staff will attend yearly abuse training

Training will be reviewed at quarterly QA meetings

Completion Date: *03/18/2022*

202 - Prohibitions *(continued)*

Document Submission ***Implemented***

second submission of documents

231e - No Objection Statement

1. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept***

addendum was immediately signed and added to contract on 3/17/2022 (see attached)
Community under new management
ED/BOM will audit 100% of resident files for compliance by 4/5/2022
Any missing information will immediately be obtained and placed in file
BOM will do 10% audit of resident files monthly
audits will be reviewed at Quarterly QA meetings
Completion Date: *04/15/2022*

Document Submission ***Implemented***

second submission of documents

234a - Admission Support Plan

1. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. However, the resident's initial support plan was completed on [redacted]/21.

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. However, the resident's initial support plan was not completed.

Plan of Correction ***Accept***

Community under new management. Per DHS visit 3/17/22, ED has been notified to add note to resident charts missing information regarding the knowledge that previous administration did not complete certain aspects of paperwork compliance appropriately.
New management has audited 100% of resident charts as of 3/21/2022
Missing (misdated) initial support plans are not able to be fixed or completed by this team, but support plans will be completed based on current resident information with dates corresponding to the current time. These support plans will need to be considered initial plans moving forward (as per DHS surveyor on 3/17 visit)
Residents with missing support plans will have a plan completed by 4/5/2022.
***support plan was immediately completed for resident #2** (See attached support plan)*

234a - Admission Support Plan (continued)

Annual support plan for resident #1 was completed per regulation (see attached support plan)
Support plans will be completed within the 72-hour regulatory window upon admission and yearly thereafter, unless in the event of a significant change.
Family/resident will be included in plan and will provide signature at time of completion.
Nursing director will audit 10% of charts monthly for compliance of completion and dating
Audits will be reviewed at quarterly QA meetings
Completion Date: *04/15/2022*

Document Submission ***Implemented***

second submission of documents

234d - Support Plan Revision

1. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #2 was completed on [redacted]/22; however, on 03/17/22, resident was observed in clothing soiled with feces. According to staff interviews, the resident needs assistance cleansing after a bowel movement. The resident's support plan has not been revised to reflect this change.

Plan of Correction ***Accept***

Upon review of resident's support plan, it is the community's position that this resident's plan is correct in that the resident does not require assistance with toileting. [redacted] regularly toilets and performs [redacted] own hygiene daily. Therefore, the need to update the plan does not exist.
At the time the surveyor was in, the resident had one episode of loose stool which the staff assisted [redacted] with at the request of the nursing director.
Support plans will be updated immediately as needs occur by the Nursing Director
ED/DON will audit 10% of charts for completion of updates monthly
Audits will be reviewed at quarterly QA meetings
Completion Date: *03/18/2022*

Document Submission ***Implemented***

second submission of documents

234e - Involvement/Participation

1. Requirements

2600.
234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

Resident #2's support plan was developed on [redacted]/22. Neither the resident nor the resident's designated person were involved in the development.

Plan of Correction ***Accept***

Community under new management. Per DHS visit 3/17/22, ED has been notified to add note to resident charts missing information regarding the knowledge that previous administration did not complete certain aspects of paperwork compliance appropriately.

234e - Involvement/Participation (continued)

New management has audited 100% of resident charts as of 3/21/2022
Missing (misdated) initial support plans are not able to be fixed or completed by this team, but support plans will be completed based on current resident information with dates corresponding to the current time. These support plans will need to be considered initial plans moving forward (as per DHS surveyor on 3/17 visit)
Residents with missing support plans will have a plan completed by 4/15/2022.
support plan in question was immediately reviewed with resident and signed
(See attached support plan)
Support plans will be completed within the 72-hour regulatory window upon admission and yearly thereafter, unless in the event of a significant change.
Family/resident will be included in plan and will provide signature at time of completion.
Unsigned support plans will be reviewed with family/resident.
Signatures will be obtained at that time.
Nursing director will audit 10% of charts monthly for compliance of completion and dating
Audits will be reviewed at quarterly QA meetings
Completion Date: *04/15/2022*

Document Submission ***Implemented***

second submission of documents