Department of Human Services
Bureau of Human Service Licensing

June 16, 2022

[redacted]
LCB CHADDS FORD LLC
[redacted]

RE: THE RESIDENCE AT CHADDS FORD
1778 WILMINGTON PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14536

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/24/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Mia Johnson

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: *THE RESIDENCE AT CHADDS FORD* **License #**: *14536* **License Expiration**: *12/06/2022*

Address: *1778 WILMINGTON PIKE, GLEN MILLS, PA 19342*

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

Administrator

Name: [redacted] **Phone**: *6102223333* **Email**: [redacted]

Legal Entity

Name: *LCB CHADDS FORD LLC*

Address: *3 EDGEWATER DRIVE, SUITE 101, NORWOOD, MA, 2062*

Phone: *6102223333* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/08/2019* **Issued By**: *Chadds Ford Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/24/2022*

Inspection Dates and Department Representative

03/24/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *108* **Residents Served**: *53*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *21* **Residents Served**: *13*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *53*

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

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

03/24/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/05/2022*

Inspections / Reviews *(continued)*

05/18/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/21/2022*

06/16/2022 - 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

On 3/11/22, resident #1 did not receive their evening medications that had been prescribed by the doctor. The incident was not reported to the Department until 3/13/22.

Plan of Correction ***Accept***

Immediate Response: The resident was assessed for adverse effects, due to not receiving their evening medication. No adverse effects were assessed. The resident's POA and physician had been notified and no new orders were received.

Route cause/investigation: Staff person A, the medication technician did not follow doctor's orders and administer resident #1's medications as prescribed. Staff person A signed the medications out, to give to the resident, the resident needed personal care at the time, prohibiting the medication technician from administering the medications once prepared. The medication technician failed to follow medication administration protocol, which includes not signing for the administration of medications until the administration is complete. They also failed to follow up on their own job tasks and did not return to the resident after the personal care was complete to administer the prescribed medication.

Prevention of future occurrence: The medication technician, staff person A will be coached on reporting a medication omission immediately to the shift supervisor, they will also be coached on organizational skills for follow-up and follow through of their job tasks. All medication technicians and licensed nursed will be coached on immediately reporting a medication omission to their supervisor upon discovery, the regulation which requires the resident (if applicable), POA, physician and the Department of Human Services to be notified within 24 hours of discovering the omission. All licensed nurses will be coached on reporting a medication omission immediately upon gaining knowledge to the Resident Care Director and Executive Director.

This coaching will be completed by the Executive Director and/or the Resident Care Director and will be completed by May 20, 2022.

Completion Date: *05/20/2022*

Document Submission ***Implemented***

Provide documentation

60a - Staff/Support Plan

1. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident #1 did not receive [redacted] evening medications on 3/11/22, as specified in the resident's assessment and support

60a - Staff/Support Plan (continued)

plan. According to staff person A, these services could not be provided because when [redacted] went to administer the medications, resident #1 needed to be changed. The caregiver then took the resident to [redacted] apartment to be changed. Staff person A went to another floor to continue administering medications. Staff person A completely forgot that [redacted] needed to return to resident #1 because [redacted] was working double shifts between three floors.

Plan of Correction ***Accept***

Immediate response: The resident was assessed for adverse effects, due to not receiving their evening medication. No adverse effects were assessed. The resident's POA and physician were notified of the omission and no new orders were received. The medication administration assignment that staff person A was on that evening was reviewed to verify that the assignment was manageable. The medication administration pass for the evening of 3/11/2022 that staff person A was assigned to had a total of 19 residents who were to receive medications on the evening medication administration pass between 4pm and 8pm, a 4-hour time span, which allowed for approximately 13 minutes for each resident's medication administration. Medication administration was their primary focus during their shift, and only assists in other care in the event of an emergency, which there were none that occurred that evening. The schedule was also reviewed due to staff person A working a double shift. As reported by the Resident Care Director and confirmed by staff person A, staff person A had agreed to the 16-hour shift in advance, it was not a last-minute fill, therefore [redacted] should have been prepared for the workload.

Route cause/investigation: Staff person A, the medication technician did not follow doctor's orders and administer resident #1's medications as prescribed. Staff person A signed the medications out, to give to the resident, the resident needed personal care at the time, prohibiting the medication technician from administering the medications once prepared. The medication technician failed to follow medication administration protocol, which includes not signing for the administration of the medications until the administration is complete. They also failed to follow up on their own job tasks and did not return after the personal care was complete to administer the prescribed medication.

Prevention of future occurrence: The medication technician, staff person A will be coached on reporting a medication omission immediately to the shift supervisor, they will also be coached on organizational skills for follow-up and follow through of their job tasks. Staff person A will not be assigned for two consecutive shifts as a medication technician on future schedules.

This coaching will be completed by the Executive Director and/or the Resident Care Director and will be completed by May 20, 2022.

Completion Date: *05/20/2022*

Document Submission ***Implemented***

182c - Medication Administration

1. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.

182c - Medication Administration *(continued)*

3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 3/11/22, the home failed to administer medications in the evening to resident #1, who requires assistance with medication administration.
From 3/09/22 to 3/15/22, the home failed to administer Nuplazid 34 mg to resident #2, who requires assistance with medication administration.

Plan of Correction ***Accept***

Immediate response: Resident #1 was assessed for adverse effects, due to not receiving their evening medication. No adverse effects were assessed. The resident's physician had been notified of the occurrence on 3/13/2022 and no new orders were received.
Resident #2 was assessed for adverse effects due to not receiving Nuplazid as ordered. No adverse effects were assessed. The family and the physician were notified of the omission and the assessment.

Route cause/investigation: Staff person A, the medication technician did not follow doctor's orders and administer resident #1's medications as prescribed. Staff person A signed the medications out, to give to the resident, the resident needed personal care at the time, prohibiting the medication technician from administering the medications once prepared. The medication technician failed to follow medication administration protocol, which includes not signing for the administration of medications until the administration is complete. They also failed to follow up on their own job tasks and did not return to the resident after the personal care was complete to administer the prescribed medication.
Resident #2 did not receive Nuplazid as prescribed as a result of the pharmacy discontinuing the medication due to the insurance company denying authorization of coverage. The pharmacy was not aware that the ordering physician had supplied sample packs of the medication. The nurse approved the discontinuation of the medication in the electronic que which removed it from the medication administration record without receiving a written or electronic order to discontinue the medication.

Prevention of future occurrence: The medication technician, staff person A will be coached on reporting a medication omission immediately to the shift supervisor, they will also be coached on organizational skills for follow-up and follow through of their job tasks. Staff person A will not be assigned for two consecutive shifts as a medication technician on future schedules.
All licensed nurses will be coached on the procedure for approving medication orders in the electronic que. All orders in the que must be verified and accompanied by a written or electronic copy of the order which must be placed in the resident file.

This coaching will be completed by the Executive Director and/or the Resident Care Director and will be completed by May 20, 2022.

Completion Date: *05/20/2022*

182c - Medication Administration *(continued)*

Document Submission ***Implemented***

183f - Discontinued Medications

1. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 03/24/22, PEG 3350 Osmotic Laxative prescribed for resident #1, was in the home's medication cart; however, the medication was expired on 11/26/21.

On 03/24/22, Nuplazid 34 mg prescribed for resident #2, was in the home's medication cart; however, the medication was expired on 02/2022.

Plan of Correction ***Accept***

Immediate response: The PEG 3350 Osmatic Laxative for resident #1 was immediately removed from the medication cart and was reordered from the pharmacy. Resident #1 was ordered PEG 3350 Osmatic Laxative 17 grams by mouth daily as needed. The resident's medication administration record was thoroughly reviewed. The resident had not received the expired medication, the last dose of the medication was administered as needed on August 25, 2021 @ 7:38pm.
The Nuplazid 34 mg for resident #2 that was found to be expired was immediately removed from the medication cart. The POA and ordering prescriber were notified of the expired samples. They ordering prescriber provided replacement samples the same day that were not expired. The resident was assessed for adverse effects as a result of receiving 5 doses of the expired sample medication. No adverse effects were assessed.

Route cause/investigation: Resident #1 had not utilized the PEG Osmatic Laxative as needed since August 25, 2021, therefore the expiration date had been overlooked.
The medication Nuplazid had been received on March 4, 2022, by the ordering physician in sample packages. The ordering physician, the nurse accepting the medication and those who administered the medication failed to recognize the expiration date.

Prevention of future occurrence: All licensed nurses and medication technicians will be coached on the need to audit each resident's medications on a weekly basis. This audit will include verifying that there is a diagnosis on the medication administration record for all medications, all as needed medications are available, there is at least a one-week supply of all routine medications, label on medication matches what is written on the medication administration record, the resident's area in the cart is clean, no medications are expired along with the corrective action taken to address any discrepancies found. The medication audit must be returned the Resident Care Director/Executive Director at the end of the assigned shift and reviewed for accuracy and completion. Please see attached audit tool.

This coaching will be completed by the Executive Director and/or the Resident Care Director and will be completed by May 20, 2022. The audit tool will be in place by May 20, 2022.

183f - Discontinued Medications (continued)

Completion Date: *05/20/2022*

Document Submission ***Implemented***

184c - Sample Prescription Meds.

1. Requirements

2600.
184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

Sample Nuplazid 34 mg belonging to resident #2 were in the med cart. The labels for these samples did not include, the date the prescription was issued and the name and title of the prescriber.

Plan of Correction ***Accept***

Immediate response: The Nuplazid was correctly labeled with the prescription date, and the prescribing physician information when the replacement sample packages were obtained.

Route cause/investigation: The nurse who had accepted the sample medication did not properly label the sample medication with the date the medication was ordered or the name of the prescribing physician.

Prevention of future occurrence: All licensed nurses and medication technicians will be coached on the need to ensure that all sample medication is properly labeled with the required information which includes the name of the resident, the date the medication was ordered, the prescribed dosage, instructions for administration, and the name of the prescribing physician. A weekly audit tool which includes comparing the medication label with the MAR for accuracy will be instituted. Please see attached audit tool.

This coaching will be completed by the Executive Director and/or the Resident Care Director and will be completed by May 20, 2022. The audit tool will be in place by May 20, 2022.

Completion Date: *05/20/2022*

Document Submission ***Implemented***

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 #1 is prescribed Acetaminophen Oral Tablet 500 mg, Buspirone HC1 Oral Tablet 5 mg, Famotidine Oral Tablet 20 mg, Melatonin Tablet 5 mg, Quetiapine Fumarate Oral Tablet 100 mg, Refresh Ophthalmic Solution 1.4 - 0.6 % and

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

Trazadone HCl Oral tablet 100 mg. On 3/11/22. these medications were not administered but were logged on the medication administration record as administered.

Plan of Correction ***Accept***

Immediate response: The resident was assessed for adverse effects, due to not receiving their evening medication. No adverse effects were assessed. The resident's POA and physician had been notified and no new orders were received.

Route cause/investigation: Staff person A, the medication technician did not follow doctor's orders and administer resident #1's medications as prescribed. Staff person A signed the medications out, to give to the resident, the resident needed personal care at the time, prohibiting the medication technician from administering the medications once prepared. The medication technician failed to follow medication administration protocol, which includes not signing for the administration of medications until the administration is complete. They also failed to follow up on their own job tasks and did not return to the resident after the personal care was complete to administer the prescribed medication.

Prevention of future occurrence: The medication technician, staff person A will be coached on reporting a medication omission immediately to the shift supervisor, they will also be coached on organizational skills for follow-up and follow through of their job tasks. All medication technicians and licensed nursed will be coached on immediately reporting a medication omission to their supervisor upon discovery, the regulation which requires the resident (if applicable), POA, physician and the Department of Human Services to be notified within 24 hours of discovering the omission. All licensed nurses will be coached on reporting a medication omission immediately upon gaining knowledge to the Resident Care Director and Executive Director.

This coaching will be completed by the Executive Director and/or the Resident Care Director and will be completed by May 20, 2022.

Completion Date: *05/20/2022*

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

Acetaminophen Oral Tablet 500 mg, 2 tablets by mouth twice a day, is prescribed for resident #1. However, this medication was not administered on 03/11/2021 at 2:00 p.m.
Buspirone HC1 Oral Tablet 5 mg, 1 tablet by mouth, is prescribed for resident #1. However, this medication was not administered on 03/11/2021 in the aftrenoon.
Famotidine Oral Tablet 20 mg, 1 tablet by mouth twice a day, is prescribed for resident #1. However, this medication was not administered on 03/11/2021 in the evening.
Melatonin Tablet 5 mg, 2 tablets by mouth at bedtime, is prescribed for resident #1. However, this medication was not administered on 03/11/2021 at bedtime.
Quetiapine Fumarate Oral Tablet 100 mg, 1 tablet by mouth at bedtime, is prescribed for resident #1. However, this medication was not administered on 03/11/2021 at bedtime.

187d - Follow Prescriber's Orders (continued)

Refresh Ophthalmic Solution 1.4 - 0.6 % three times a day, is prescribed for resident #1. However, this medication was not administered on 03/11/2021 in the afternoon or at bedtime.
Trazadone HCl Oral tablet 100 mg by mouth every day, is prescribed for resident #1. However, this medication was not administered on 03/11/2021 at 8:00 p.m.
Nuplazid Oral Capsule 34 MG 1 tablet by mouth daily is prescribed for resident #2. However, this medication was not administered from 03/9/2022 to 03/15/2022.

Repeat violation 07/16/2021; 05/11/2021.

Plan of Correction ***Accept***

Immediate response: Resident #1 was assessed for adverse effects, due to not receiving their medication as prescribed. No adverse effects were assessed. The resident's physician had been notified of the occurrence on 3/13/2022 and no new orders were received.
Resident #2 was assessed for adverse effects due to not receiving Nuplazid as ordered. No adverse effects were assessed. The family and the physician were notified of the omission and the assessment.

Route cause/investigation: Staff person A, the medication technician did not follow doctor's orders and administer resident #1's medications as prescribed. Staff person A signed the medications out, to give to the resident, the resident needed personal care at the time, prohibiting the medication technician from administering the medications once prepared. The medication technician failed to follow medication administration protocol, which includes not signing for the administration of medications until the administration is complete. They also failed to follow up on their own job tasks and did not return to the resident after the personal care was complete to administer the prescribed medication.
Resident #2 did not receive Nuplazid as prescribed as a result of the pharmacy discontinuing the medication due to the insurance company denying authorization of coverage. The pharmacy was not aware that the ordering physician had supplied sample packs of the medication. The nurse approved the discontinuation of the medication in the electronic que which removed it from the medication administration record without receiving a written or electronic order to discontinue the medication.

Prevention of future occurrence: The medication technician, staff person A will be coached on reporting a medication omission immediately to the shift supervisor, they will also be coached on organizational skills for follow-up and follow through of their job tasks. Staff person A will not be assigned for two consecutive shifts as a medication technician on future schedules.
All licensed nurses will be coached on the procedure for approving medication orders in the electronic que. All orders in the que must be verified and accompanied by a written or electronic copy of the order which must be placed in the resident file.

This coaching will be completed by the Executive Director and/or the Resident Care Director and will be completed by May 20, 2022.

Completion Date: *05/20/2022*

Document Submission ***Implemented***

252 - Record Content

1. Requirements

252 - Record Content *(continued)*

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

The record for resident #1 does not include an incident report for the resident.

The record for resident #2 does not include an incident report for the resident.

Plan of Correction ***Accept***

Immediate response: A copy of the reportable incident submitted to the Department of Human Services was placed in the files for both resident #1 and resident #2.

Route cause/investigation: A copy of the reportable incident was placed in the reportable incident binder after being submitted to the Department of Human Services however, a copy was not placed in the resident file.

Prevention of future recurrence: All reportable incidents will be completed/reviewed and /or submitted to DHS as required by the Executive Director or designee. At the completion of the transmittal a copy of the report will be

252 - Record Content (continued)

placed in both the resident file and the reportable incident binder by the Executive Director.

This will be the ongoing responsibility of the executive Director. This correction has been made as of May 5, 2022.

Completion Date: *05/05/2022*

Document Submission ***Implemented***