Department of Human Services
Bureau of Human Service Licensing

June 8, 2022

[REDACTED],
VS WOODS LLC

RE: THE WOODS AT CEDAR RUN
824 LISBURN ROAD
CAMP HILL, PA, 17011
LICENSE/COC#: 33132

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/29/2022, 03/30/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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 WOODS AT CEDAR RUN* **License #**: *33132* **License Expiration**: *12/31/2022*

Address: *824 LISBURN ROAD, CAMP HILL, PA 17011*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *VS WOODS LLC*

Address: *6600 BROOKTREE COURT,SUITE 1000, INTEGRACARE CORPORATION, WEXFORD, PA, 15090*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/19/1997* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/30/2022*

Inspection Dates and Department Representative

03/29/2022 - On-Site:

03/30/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *59*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *19* **Residents Served**: *13*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *59*

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

Have Mobility Need: *15* **Have Physical Disability**: *0*

Inspections / Reviews

03/29/2022 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/17/2022*

Inspections / Reviews *(continued)*

05/25/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/02/2022*

06/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/08/2022*

06/08/2022 - 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 [redacted], a medication error occurred when Resident #1 missed a weekly dose of prescribed [redacted]. The home did not report this incident to the department.

Plan of Correction ***Accept***

By 05/31/2022, and then after six months, the EOO/RWD or designee will conduct a training with certified medication associates and nurses, to cover appropriate reporting procedures relating to missed medications.
Training conducted 5/17/2022 and will be conducted in six months.
Beginning 4/15/2022 ED/RWD will review any medication errors bi weekly for a period of six month to ensure proper reporting.

Completion Date: *10/14/2022*

Document Submission ***Implemented***

By 05/31/2022, and then after six months, the EOO/RWD or designee will conduct a training with certified medication associates and nurses, to cover appropriate reporting procedures relating to missed medications.
Training conducted 5/17/2022 and will be conducted in six months.
Beginning 4/15/2022 ED/RWD will review any medication errors bi weekly for a period of six month to ensure proper reporting.

Plan has been 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 for Resident #1, who was admitted to the home on [redacted], was not signed by the resident.

The resident-home contract for Resident #2, who was admitted to the home on [redacted], was not signed by the resident.

Plan of Correction ***Accept***

An ongoing monitoring component was implemented 4/1/2022 and EOO has been reviewing all contracts since Annual inspection. For a period of six months, the EOO will review all new contracts to ensure resident signatures are in place, or attempted.

Completion Date: *10/01/2022*

Document Submission ***Implemented***

An ongoing monitoring component was implemented 4/1/2022 and EOO has been reviewing all contracts since Annual inspection. For a period of six months, the EOO will review all new contracts to ensure resident signatures are in place, or attempted.

25b - Contract Signatures (continued)

Plan has been implemented

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

There were not at least two staff persons who are trained and certified in first aid and CPR present in the home, based on the census of the home, during the 11PM to 7AM shift as follows:

DATE	*CENSUS*	*STAFFING*
3/13/22	*59*	*one staff person certified in first aid and CPR*
3/14/22	*59*	*one staff person certified in first aid and CPR; one certified in CPR only*
3/15/22	*58*	*one staff person certified in first aid and CPR*
3/16/22	*58*	*one staff person certified in CPR only*
3/17/22	*58*	*one staff person certified in first aid and CPR*
3/18/22	*57*	*one staff person certified in first aid and CPR; one certified in CPR only*
3/19/22	*57*	*one staff person certified in CPR only*
3/20/22	*56*	*one staff person certified in CPR only*
3/21/22	*56*	*one staff person certified in first aid and CPR*
3/22/22	*57*	*one staff person certified in first aid and CPR; one certified in CPR only*
3/23/22	*56*	*one staff person certified in first aid and CPR; two certified in CPR only*
3/24/22	*56*	*one staff person certified in first aid and CPR; two certified in CPR only*
3/25/22	*56*	*one staff person certified in CPR only*
3/26/22	*55*	*one staff person certified in first aid and CPR*
3/27/22	*55*	*one staff person certified in first aid and CPR; one certified in CPR only*

Plan of Correction ***Accept***

Immediately, 2 CPR and First Aid sessions were conducted. One on 4/6 and one on 4/19 to ensure staffing on all shifts has appropriate CPR+First aid certified ratios. RWD/ASD will review CPR certification one in each next 6 months to ensure continued compliance.

Completion Date: *04/10/2023*

Document Submission ***Implemented***

Immediately, 2 CPR and First Aid sessions were conducted. One on 4/6 and one on 4/19 to ensure staffing on all shifts has appropriate CPR+First aid certified ratios. RWD/ASD will review CPR certification one in each next 6 months to ensure continued compliance.

Plan has been implemented

132d - Evacuation

1. Requirements

2600.

132d - Evacuation *(continued)*

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

The fire drill conducted on 1/12/2022 had an evacuation time of 14 minutes and 9 seconds. The letter from the fire safety expert dated 6/22/21 states that the maximum evacuation time for the facility is 13 minutes.

Plan of Correction ***Accept***

EOO or designee will review fire drill logs monthly for a period of six months to ensure time frames are met appropriately. If time frames are not met, appropriate follow up action will occur.

Completion Date: *10/03/2022*

Document Submission ***Implemented***

EOO or designee will review fire drill logs monthly for a period of six months to ensure time frames are met appropriately. If time frames are not met, appropriate follow up action will occur.

Plan has been implemented

183b - Meds and Syringes Locked

1. Requirements

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

Description of Violation

Resident #5 is assessed as being able to self administer their medications. On [redacted] Resident #5 was not present in their room however, the door to the room was not locked. Prescribed [redacted] was accessible on top of the kitchenette table. [redacted] were unlocked and accessible in Resident #5's bathroom.

Plan of Correction ***Accept***

Resident was educated on 03/31/2022 regarding securing medications. Beginning week of 4/8/2022 to ensure compliance, wellness personnel will inspect resident #5s room weekly, for 3 months. to ensure that medications are locked and secure.

Completion Date: *07/11/2022*

Document Submission ***Implemented***

Resident was educated on 03/31/2022 regarding securing medications. Beginning week of 4/8/2022 to ensure compliance, wellness personnel will inspect resident #5s room weekly, for 3 months. to ensure that medications are locked and secure.

Plan has been implemented

185a - Implement Storage Procedures

1. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 has a physician order to have their blood sugar checked daily at 8:00 AM. On 3/29/22 the MAR (medication administration record) for Resident #1 has a reading of 75 recorded. The glucometer for Resident #1 does not have any reading for 3/29/22.

Plan of Correction ***Accept***

For a period of 3 months, RWD will review the MAR for resident #1 and compare it to glucometer readings to ensure correct readings. Beginning 4/1/2022, screening process was conducted daily. Documentation included noting screening process. and daily notation.

Completion Date: *07/11/2022*

Document Submission ***Implemented***

For a period of 3 months, RWD will review the MAR for resident #1 and compare it to glucometer readings to ensure correct readings. Beginning 4/1/2022, screening process was conducted daily. Documentation included noting screening process. and daily notation.

Plan has been implemented

187c - Refusal of Medication

1. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 3/19/22 at 5 PM Resident #4 refused to take a scheduled dose of [redacted]. *The home did not report the refusal to the prescriber.*

Plan of Correction ***Accept***

By 05/31/2022, and then after six months RWD/ASD or designee will conduct a training on appropriate procedures regarding medication refusal procedures and appropriate follow up action.
Training was completed by 5/31/2022 for all persons passing medications. Additional training will be provided by 11/31/2022. Beginning 4/8/2022 RWD or designee will review refusals bi-weekly for a period of six months to ensure refusals are reported to the provider. 3/19/2022 refusal reported to the provider.

Completion Date: *10/07/2022*

Document Submission ***Implemented***

By 05/31/2022, and then after six months RWD/ASD or designee will conduct a training on appropriate procedures regarding medication refusal procedures and appropriate follow up action.
Training was completed by 5/31/2022 for all persons passing medications. Additional training will be provided by 11/31/2022. Beginning 4/8/2022 RWD or designee will review refusals bi-weekly for a period of six months to ensure refusals are reported to the provider. 3/19/2022 refusal reported to the provider.

Plan has been 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

The RASPS (Resident Assessment and Support Plan) for Resident #1 dated [redacted] and Resident #3, dated [redacted] were not signed by the staff person that developed the support plan.

Repeat Violation - 5/18/2020, 9/4/2019

Plan of Correction ***Accept***

Beginning 4/15/2022 the RWD or designee will review all RASPs for a period of six months to ensure signatures of the assessors is captured. RWD audited existing RASPS to ensure signatures of RASP completer is present. The RWD or designee will review all new RASPs weekly for a period of six months to ensure signatures of the assessors is captured.

Completion Date: *10/14/2022*

Document Submission ***Implemented***

Beginning 4/15/2022 the RWD or designee will review all RASPs for a period of six months to ensure signatures of the assessors is captured. RWD audited existing RASPS to ensure signatures of RASP completer is present. The RWD or designee will review all new RASPs weekly for a period of six months to ensure signatures of the assessors is captured.

Plan has been implemented

231c - Preadmission Screening

1. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] A written cognitive preadmission screening was not completed.

Plan of Correction ***Accept***

Beginning 4/15/2022 for a period of six months, RWD and Sales team will review all MC contracts to ensure that Pre-Admission screenings are completed. An audit was completed 4/15/2022 to ensure all residents had a completed pre-admission screening. New Admission paperwork to MC will be reviewed for a period of 6 months to ensure compliance.

Completion Date: *10/11/2022*

Document Submission ***Implemented***

Beginning 4/15/2022 for a period of six months, RWD and Sales team will review all MC contracts to ensure that Pre-Admission screenings are completed. An audit was completed 4/15/2022 to ensure all residents had a completed pre-admission screening. New Admission paperwork to MC will be reviewed for a period of 6 months to ensure compliance.

231c - Preadmission Screening (continued)

Plan has been implemented

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

Plan of Correction ***Accept***

Beginning 4/1/2022 for a period of six months, RWD will review all MC support plans to ensure that support plans are completed within 72 hours. Beginning immediately after inspection all new admissions were reviewed to ensure RASPs were completed within 72 hours. Documentation included.

Completion Date: *10/01/2022*

Document Submission ***Implemented***

Beginning 4/1/2022 for a period of six months, RWD will review all MC support plans to ensure that support plans are completed within 72 hours. Beginning immediately after inspection all new admissions were reviewed to ensure RASPs were completed within 72 hours. Documentation included.

Plan has been implemented