



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [REDACTED]

Sent via e-mail [REDACTED]

March 1, 2023

[REDACTED]

[REDACTED]

Success Rehabilitation, Inc.
5666 Clymer Road
Quakertown, Pennsylvania 18951

RE: Success Rehabilitation at Rock Ridge
License #: 12730

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on April 14, 2022 of the above facility, we have determined that your submitted plan of correction is not fully implemented. Continued compliance must be maintained.

Sincerely,

[REDACTED]

[REDACTED]

Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *SUCCESS REHABILITATION AT ROCK RIDGE* License #: *12730* License Expiration: *08/18/2022*
Address: *5666 CLYMER ROAD, QUAKERTOWN, PA 18951*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *SUCCESS REHABILITATION, INC.*
Address: *5666 CLYMER ROAD, QUAKERTOWN, PA, 18951*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *31* Waking Staff: *23*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *04/14/2022*

Inspection Dates and Department Representative

04/14/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *35* Residents Served: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* Are 60 Years of Age or Older: *3*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *10* Have Physical Disability: *1*

Inspections / Reviews

04/14/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/25/2022*

Inspections / Reviews *(continued)*

01/19/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/20/2022

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/05/2023

03/01/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/28/2023

Reviewer: [REDACTED]

Follow-Up Type: Exception

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On 4/14/22, at 9:30 am, an agent of the Department, requested access to the home's reportable incidents. Staff person A reported at 11:30 am that the reportable incidents could not be found .

Plan of Correction

Directed (redacted) - 12/22/2022)

All reportable incidents are collected and filed in the DHS Binder that the PCH Administrators keep updated with all mandatory information/forms that are required to be available when a DHS licensing representative is on site for immediate access. A copy of the reportable incident is also kept in the individual Resident's Case Record/Electronic Health Record when applicable.

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS (redacted) 12/22/22)

- 1. The administrator will educate all staff responsible for providing documents to the Department within the next 10 days and maintain copies of the training for the Departments review.
- 2. The administrator or nursing staff will conduct monthly audits of reportable incidents to ensure the copies are located in the residents record or the homes DHS binder for the next six, starting immediately.

Directed Completion Date: 01/02/2023

Evidence of Completion

Implemented (redacted) - 03/01/2023)

- 1. The PCH Administrator included this education in an all staff meeting on 12/28/22. Meeting minutes were also provided and reviewed with staff that were unable to attend this meeting. Attached Copy noting areas covered in the 12/28/22 staff meeting.
- 2. The PCH Administrator is conducting monthly audits of reportable incidents to ensure tht copies are located as applicable in the individual resident record and SRI's DHS Binder. This plan will remian in place moving forward. Audit records can be made available upon request when onsite for future inspections if any errors noted.

16c - Written Incident Report

2. 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)/21, it was reported that resident #1 touched a visitor to the home inappropriately. The home did not report this incident to the department until (redacted)/21.

Plan of Correction

Directed (redacted) - 12/22/2022)

The incident in question occurred on over a weekend with a new on call administrator that was unfamiliar with the process of reporting an incident to the Department's PCH Regional Office or Complaint Hotline within 24 hours. All on calls were retrained in this process with a PCH Administrator now assigned on a rotating weekly schedule as back up in the event an incident that requires reporting should occur again during non- business hours during the weekday and/or weekend.

16c - Written Incident Report (continued)

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS [REDACTED] 12/22/22)

1. The administrator or training personnel will conduct a training with all staff on the reportable incident policy within 10 days of receipt of this plan of correction. Documentation of the training will be maintained for the Departments review.
2. The administrator will review all reportable incidents at least weekly for the next six months, to ensure the incidents are reported in accordance with the regulations, starting immediately.

Directed Completion Date: 01/02/2023

Evidence of Completion

Implemented [REDACTED] - 03/01/2023)

1. The PCH Administrator included the reportable incident policy education/review in an all staff meeting on 2/28/22. Meeting minutes were also provided and reviewed with staff that were unable to attend this meeting. Attached Copy noting areas covered in the 12/28/22 staff meeting.
2. The PCH Administrator is conducting monthly audits of reportable incidents to ensure tht copies are located as applicable in the individual resident record and SRI's DHS Binder. This plan will remian in place moving forward. Audit records can be made available upon request when onsite for future inspections if any errors noted.

16f - Copy of Reportable Incident or Condition

3. Requirements

2600.

16.f. The home shall keep a copy of the report of the reportable incident or condition.

Description of Violation

On 4/14/22, copies of the homes reportable incidents were requested but they could not be provided because their location was unknown.

Plan of Correction

Directed [REDACTED] - 12/22/2022)

All reportable incidents are collected and filed in the DHS Binder that the PCH Administrators keep updated with all mandatory information/forms that are required to be available when a DHS licensing representative is on site for mmediate access. A copy of the reportable incident is also kept in the individual Resident's Case Record/Electronic ealth Record when applicable.

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS [REDACTED] 12/22/22)

1. The administrator will conduct a training to all staff on the importance of maintaining copies of reportable incidents in the residents record, within 10 days of receipt of this plan of correction. Documentation of the training will be maintained for the Departments review.
2. The administrator or nursing staff will conduct a monthly audit of reportable incidents to ensure the copies are ocated in the residents record or the homes DHS binder for the next six months, starting immediately.

Directed Completion Date: 01/02/2023

vidence of Completion

Implemented [REDACTED] 03/01/2023)

1. The PCH Administrator included the reportable incident policy education/review in an all staff meeting on 12/28/22. Meeting minutes were also provided and reviewed with staff that were unable to attend this meeting. Attached Copy noting areas covered in the 12/28/22 staff meeting.
2. The PCH Administrator is conducting monthly audits of reportable incidents to ensure tht copies are located as applicable in the individual resident record and SRI's DHS Binder. This plan will remian in place moving forward.

16f - Copy of Reportable Incident or Condition (continued)

Audit records can be made available upon request when onsite for future inspections if any errors noted.

23b Instrumental Activities of Daily Living Assistance**4. Requirements**

2600.

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

Description of Violation

The assessment and support plan for resident #1, dated [REDACTED]/21, indicates the resident requires 1:1 supervision from 7:00am to 10:00 pm [REDACTED]. Resident #1 does not receive this assistance as required. The March 2022 1:1 staff log shows that resident #1 only received 12 hours of 1:1 from 7:00am to 7:00 pm every day in March. Furthermore, on the [REDACTED]/22-[REDACTED]/22, [REDACTED] 22, [REDACTED]/22, [REDACTED]-[REDACTED], [REDACTED]/22, [REDACTED]/22, [REDACTED]/22, and [REDACTED]/22, resident #1 shared a 1:1 staff member with another resident meaning it was not a true 1:1.

Plan of Correction

Directed ([REDACTED] 12/22/2022)

Success Rehabilitation Inc is contracted with 2 nursing agencies, [REDACTED]. There is an approved pool of agency staff that have been trained to work shifts with residents at SRI. In the event that SRI staffing is not available for a shift with a 1:1 resident, agency staff will be scheduled and utilized to ensure proper support and coverage is provided.

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS ([REDACTED] 12/22/22)

- 1. The administrator or nursing supervisor will review the 1:1 log daily to ensure all residents receive the staff to meet their needs in accordance with the RASP, starting immediately.*
- 2. The administrator or nursing supervisor will conduct periodic, at least bi-weekly, checks on residents requiring 1:1 staff to ensure the residents are receiving the required hours of additional staffing to meet their needs for the next six months, starting immediately.*
- 3. The administrator or training personnel will conduct a training will all Direct Care Staff and agency staff to ensure they are aware of the residents requiring 1:1 staffing needs are being met and how, within the next 10 days. Documentation of the training will be maintained for the Departments review.*

Directed Completion Date: 01/02/2023

Evidence of Completion

Implemented ([REDACTED] - 03/01/2023)

1 and 2. Staff Schedules Team/Member which includes the PCH Administrator will review the 1:1 log daily in AM/PM huddle groups to ensure all residents are assigned staff to meet their needs accordance with individual RASP. Changes/coverage is provided due to staff call outs, illnesses, emergencies, etc. Daily checks/audits are included in this process to ensure compliance is maintained.

3. The PCH Administrator included the education/review of procedures to ensure the residents are receiving required 1:1 staffing needs where applicable in an all staff meeting on 12/28/22. Meeting minutes were also provided and reviewed with staff that were unable to attend this meeting. Attached Copy noting areas covered in the 12/28/22 staff meeting.

42b - Abuse**5. Requirements**

2600.

42b - Abuse (continued)

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

██████████ ██████████ Resident #1 has lived in the home since ██████████/12 and according to the resident's preadmission screening requires 24 hour supervision. Resident #1's Resident Assessment and Support Plan (RASP) dated ██████████/21 states that Resident #1's ██████████ requires 1:1 supervision to ensure safety ██████████. According to the RASP dated ██████████/21, the 1:1 supervision should be 7:00 am to 10:00 pm. According to documentation provided by the home, resident #1 is not receiving 1:1 supervision. An internal incident report dated ██████████/22 describes an incident between resident #1 and resident #2, ██████████. The incident occurred on ██████████/22 at ██████████ am, resident #1 did not have 1:1 supervision at that time. An internal incident report dated ██████████/22 describes an incident that occurred at ██████████ pm between resident #1 and a visitor to the home ██████████. There was no 1:1 supervision for resident #1 at the time of this incident. Resident #1's therapist reports that resident #1 stays in the resident's room 85-90% of the day because the resident is afraid of making a bad decision and being kicked out of the home.

Plan of Correction

Directed ██████████ - 12/22/2022)

Success Rehabilitation Inc is contracted with 2 staff agencies, ██████████. There is an approved pool of agency staff that have been trained to work shifts with residents at SRI. In the event that SRI staffing is not available for a shift with a 1:1 resident, agency staff will be scheduled and utilized to ensure proper support and coverage is provided.

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS ██████████ 12/22/22)

1. The administrator or an outside agency will conduct a training on abuse and neglect to all direct care staff and agency staff within the next 15 days. Documentation of the training will be maintained for the Departments review.
2. The administrator or nursing supervisor will review the 1:1 log daily to ensure all residents receive the staff to meet their needs in accordance with the RASP, starting immediately.
3. The administrator or nursing supervisor will conduct periodic, at least bi-weekly, checks on residents requiring 1:1 staff to ensure the residents are receiving the required hours of additional staffing to meet their needs for the next six months, starting immediately.
4. The administrator will discuss the importance of providing needed 1:1 support for residents and why not providing this is neglect during monthly staff meetings for the next six months. Documentation of the agenda and attendance record will be maintained for the Departments review.

Directed Completion Date: 01/05/2023

Evidence of Completion

Not Implemented ██████████ - 03/01/2023)

1. PCH Administrator completed the training and review of policy and procedures on the topic of resident abuse and neglect in an all staff meeting on 12/28/22. Meeting minutes were also provided and reviewed with staff that were unable to attend this meeting.
2. and 3. Staff Schedules Team/Member which includes the PCH Administrator will review the 1:1 log daily in AM/PM huddle groups to ensure all residents are assigned staff to meet their needs accordance with individual RASP. Changes/coverage is provided due to staff call outs, illnesses, emergencies, etc. Daily checks/audits are included in this process to ensure compliance is maintained.
4. Plan to continue the discussion/review of the importance of providing needed 1:1 support for residents and why

42b - Abuse (continued)

*not providing this is neglect during monthly staff meetings for 2023.
Documentation of the agenda and attendance record is maintained and available for review.*

42v - Resident-Home Contract**6. Requirements**

2600.

42.v. A resident has the right to receive services contracted for in the resident-home contract.

Description of Violation

Resident #1 is not being provided with 1:1 supervision as outlined in the Resident Assessment and Support Plan. The resident-home contract states in section D.1 that services will be provided per the Resident Assessment and Support Plan.

Plan of Correction

Directed (████) - 12/22/2022)

Success Rehabilitation Inc is contracted with 2 staff agencies ██████████. There is an approved pool of agency staff that have been trained to work shifts with residents at SRI. In the event that SRI staffing is not available for a shift with a 1:1 resident, agency staff will be scheduled and utilized to ensure proper support and coverage is provided.

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS (████) 12/22/22)

- 1. The administrator or nursing supervisor will conduct a training with all Direct Care Staff on how to identify resident needs as indicated in the RASP, within the next 10 days. Documentation of the training will be maintained for the Departments review.*
- 2. The administrator or nursing supervisor will review the 1:1 log daily to ensure all residents receive the staff to meet their needs in accordance with the RASP, starting immediately.*
- 3. The administrator or nursing supervisor will conduct periodic, at least bi-weekly, checks on residents requiring 1:1 staff to ensure the residents are receiving the required hours of additional staffing to meet their needs for the next six months, starting immediately.*
- 4. The administrator will discuss the importance of providing needed 1:1 support for residents in accordance with their RASP during monthly staff meetings for the next six months. Documentation of the agenda and attendance record will be maintained for the Departments review.*

Directed Completion Date: 01/02/2023

Evidence of Completion

Not Implemented (████) - 03/01/2023)

- 1. PCH Administrator completed the training and review on how to identify resident needs a indicated in individual RASPs in an all staff meeting on 12/28/22. Meeting minutes were also provided and reviewed with staff that were unable to attend this meeting.*
- 2. and 3. Staff Schedules Team/Member which includes the PCH Administrator will review the 1:1 log daily in AM/PM huddle groups to ensure all residents are assigned staff to meet their needs accordance with individual RASP. Changes/coverage is provided due to staff call outs, illnesses, emergencies, etc. Daily checks/audits are included in this process to ensure compliance is maintained.*
- 4. Plan to continue the discussion/review of the importance of providing needed 1:1 support for residents in accordance with their RASPs during monthly staff meetings for 2023. Documentation of the agenda and attendance record is maintained and available for review.*

65a - FS Orientation 1st Day

7. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [REDACTED]/21, did not receive orientation on the following topics until [REDACTED]/21:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services..

Plan of Correction

Directed ([REDACTED] 12/22/2022)

Success Rehabilitation Inc had two tracks for new hire orientation/training. One track was for direct support staff and the second track was for administrative/clinical team staff. Following this violation report, we recognized the importance to keep all new hire staff on the same track for orientation and training to ensure that all staff receive the same mandatory training within the required time frame.

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS ([REDACTED] 12/22/22)

1. The nursing supervisor or training personnel will ensure staff B completes this required orientation in Fire safety, within the next 5 days or be removed from the schedule. Documentation of the completion of this orientation will be maintained for the Departments review.
2. The nursing supervisor or training personnel will audit all new employee records, on the first day of hire, to ensure this required orientation on Fire Safety has been completed, starting immediately.
3. The nursing supervisor or training personnel will conduct an audit of all employee records to ensure all staff have completed the required Fire Safety orientation. If staff have not completed the orientation, the staff will be required to complete the orientation within 5 days of the audit.

Directed Completion Date: 12/27/2022

Evidence of Completion

Implemented ([REDACTED] - 03/01/2023)

1. Staff B completed this required orientation in Fire safety. Documentation of the completion of this orientation is maintained in the employee's personnel folder and available for the Departments review.
2. Plan in place for a member of the HR Team to audit all new employee records, on the first day of hire, to ensure this required orientation on Fire Safety has been completed.
3. Plan in place for a member of the HR Team to conduct an audit of all employee records to ensure all staff have completed the required Fire Safety orientation. If a staff member is found to have not completed the orientation, a

65a - FS Orientation 1st Day (continued)

member of the HR Team will ensure that staff member completes the orientation within 5 days of the audit.

65b - Rights/Abuse 40 Hours**8. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed his/her 40th scheduled work hour on or about [REDACTED] 21. However, this staff person did not complete training in the following topics:

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.

Plan of Correction

Directed ([REDACTED] - 12/22/2022)

Success Rehabilitation Inc had two tracks for new hire orientation/training. One track was for direct support staff and the second track was for administrative/clinical team staff. Following this violation report, we recognized the importance to keep all new hire staff on the same track for orientation and training to ensure that all staff receive the same mandatory training within the required time frame.

DIRECTED PLAN OF CORRECTION ADDITIONAL STEPS (SLW 12/22/22)

1. *The nursing supervisor or training personnel will ensure staff B completes this required orientation on Resident Rights, OAPSA, Incident Reporting, and Emergency Medical Plan, within the next 5 days or be removed from the schedule. Documentation of the completion of this orientation will be maintained for the Departments review.*
2. *The nursing supervisor or training personnel will audit all new employee records, after the staff has worked 40 hours of hire, to ensure this required orientation has been completed, starting immediately.*
3. *The nursing supervisor or training personnel will conduct an audit of all employee records to ensure all staff have completed the required 40 hour orientation. If staff have not completed the orientation, the staff will be required to complete the orientation within 5 days of the audit.*

Directed Completion Date: 12/27/2022

Evidence of Completion

Implemented ([REDACTED] 03/01/2023)

1. *Staff B completed this required orientation on Resident Rights, OAPSA, Incident Reporting, and Emergency Medical Plan. Documentation of the completion of this orientation is maintained in the employee's personnel folder and available for the Departments review.*
2. *Plan in place for a member of the HR Team to audit all new employee records, on the first day of hire, to ensure required orientation has been completed.*
3. *Plan in place for a member of the HR Team to conduct an audit of all employee records to ensure all staff have*

65b - Rights/Abuse 40 Hours (continued)

completed the required 40 hour orientation. If a staff member is found to have not completed the orientation, a member of the HR Team will ensure that staff member completes the orientation within 5 days of the audit.