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

March 31, 2023

[redacted], ADMINISTRATOR
CEDAR PARK ASSISTED LIVING, LLC
[redacted]

RE: ABINGTON MANOR AT MORGAN HILL
215 CEDAR PARK BOULEVARD
EASTON, PA, 18042
LICENSE/COC#: 21962

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/01/2022, 11/02/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ABINGTON MANOR AT MORGAN HILL* **License #**: *21962* **License Expiration**: *11/24/2023*

Address: *215 CEDAR PARK BOULEVARD, EASTON, PA 18042*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CEDAR PARK ASSISTED LIVING, LLC*

Address: *215 CEDAR PARK BOULEVARD, EASTON, PA, 18042*

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *04/18/2011* **Issued By**: *Williams Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *41* **Waking Staff**: *31*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/02/2022*

Inspection Dates and Department Representative

11/01/2022 On Site: [redacted]

11/02/2022 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *40*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*

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

Have Mobility Need: *1* **Have Physical Disability**: *1*

Inspections / Reviews

11/01/2022 - Full

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

Inspections / Reviews *(continued)*

02/22/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/01/2023*

03/07/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/14/2023*

03/31/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2023*

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

89b - Hot Water Temperature

1. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The water temperature measured 127.5 degrees Fahrenheit in the bathrooms of Room #124 & 315.

The water temperature measured 127.1 degrees Fahrenheit in the bathroom of Room #329.

Plan of Correction ***Accept (- 03/07/2023)***

On the day of our inspection, our Maintenance Director reported to this writer that was having trouble regulating a few of the water temperatures throughout the building. After further investigation, a call was placed to a Plumbing and Water Treatment company for repair.

The Maintenance Director is responsible for checking the water temperatures routinely on Monday, Tuesday, Thursday and Friday with the Associate ED's oversight.

All temperatures have been in normal range since the issue was fixed.

After a few visits to the facility the issue was finally located and repaired 12/11/2022. The water temperatures have been within normal limits. (see attached tracking sheet)

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented - 03/31/2023)

95 - Furniture and Equipment

2. Requirements

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

Description of Violation

A large block of ice was located on the floor in the back of the walk in freezer. Frozen water was observed coming down from the fan on the ceiling of the walk in freezer.

Plan of Correction ***Accept - 03/07/2023)***

The freezer was malfunctioning, a call was immediately placed to several refrigeration companies to schedule an evaluation of the issue.

A company was out 1/3/2023 to assess the problem and is scheduled to come to the facility 1/16/2023 for the repairs.

See the attached invoices and pictures of competed repairs on freezer.

Continued compliance will be the responsibility of the Kitchen Manager with the Executive EDs oversight.

95 Furniture and Equipment *(continued)*

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented ([redacted] - 03/31/2023)

132d - Evacuation

3. Requirements

2600.
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 8/15/22 at 7pm took 13 minutes and 30 seconds for evacuation. The letter from the fire safety expert notes a safe evacuation time of 13 minutes.

Plan of Correction ***Accept [redacted] - 03/07/2023)***

Another Fire Drill was immediately completed the next day 8/16/2022 at 4:10pm and it was completed in the allotted time required.

All fire drills to follow for the annual year were completed in the allotted time.

Please see the attached fire drill logs

The Campus Executive Director and the Associate ED will be responsible to ensure compliance for monthly drills moving forward.

See attached Fire Drill tracking form form.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented ([redacted] - 03/31/2023)

144c2 - Smoking Area Distance

4. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The lid to the smoking urn located in the homes designated smoking area was off at the time of the inspection. An empty cigarette pack and other combustible materials were noted in the urn, posing a possible fire hazard.

Plan of Correction ***Accept ([redacted] - 02/22/2023)***

The smoking urn lid was replaced and secured with screws so the top of it can't be removed and used for trash.

144c2 - Smoking Area Distance (continued)

The Maintenance Director removes the lid routinely to empty the urn of debris to ensure it's free of flammable material.

The Associate ED is responsible to follow up and ensure compliance, with the Executive Director overseeing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 03/31/2023)

181c - Self-administration Assessment

5. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 is self-administering [redacted] twice daily. The resident hasn't been assessed by a physician to be able to self-administer medications.

Plan of Correction ***Accept [redacted] - 03/07/2023)***

This was a medicated toothpaste - The facility immediately received a doctors order so the resident can safely self-administer the tooth paste and keep it in her bathroom.

Staff follow up with resident #1 daily to ensure [redacted] using the tooth paste properly and as ordered and has updated the assignment sheet to alert the direct care staff to follow up.

The PCA coordinator is responsible to update and maintain all assignment sheets, and the Director of Resident Care will be responsible for compliance with the Executive Director overseeing compliance.

see attached self admin policy that was discussed and reviewed during the staff nurses meeting 11-4-2022

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented [redacted] - 03/31/2023)

184a - Resident's Meds Labeled

6. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #2's [redacted] did not include the initials of the staff member opening the pen.

Repeat Violation: 10/14/21

184a - Resident's Meds Labeled *(continued)*

Plan of Correction ***Accept (- 02/22/2023)***

The open date, end date and initials of the staff member were immediately documented on the prescribed medication.

The staff were re-educated 11/4/2022 during a staff education meeting where all appropriate staff were again instructed on the proper process of how to do medication audits and reviewed policies and procedures.

The Med Manager and DRC will be responsible to do daily chart audits to ensure all medications are properly labeled. The Executive Director will ensure compliance.

see attachment of sign in sheet

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented (- 03/31/2023)

184b - Labeling OTC/CAM

7. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #3's [redacted] capsules did not have the residents name on the bottles.

Repeat Violation: 10/14/21

Plan of Correction ***Accept - 02/22/2023)***

The residents name was immediately documented on the prescribed medication bottles.
11/4/2022 the appropriate staff were re-educated and the OTC/CAM policy was reviewed.

The Med Manager and DRC will be responsible to do daily chart audits to ensure all medications are properly labeled. The Executive Director will ensure compliance.

The Med Manager and DRC will be responsible to do daily chart audits to ensure all medications are properly labeled. The Executive Director will ensure compliance.

see the attached policy

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented (- 03/31/2023)

185a - Implement Storage Procedures

8. Requirements

185a Implement Storage Procedures *(continued)*

2600.
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's [redacted] was not available at the time of the inspection.

Repeat Violation: 10/14/21

Plan of Correction ***Accept ([redacted] - 02/22/2023)***

In this violation, the medication is supplied by family and were immediately called and explained that moving forward, if the medicated toothpaste is not made available in a timely manner, it will be ordered from our facility pharmacy.

The family brought the toothpaste to the facility the same day.

The staff were re-educated during a staff nursing meeting 11-4-2022.

The Med Manager and DRC will be responsible to do daily chart audits to ensure all medications are properly labeled. The Executive Director will ensure compliance.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 03/31/2023)

187a Medication Record

9. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
4. Strength.

Description of Violation

Resident #2 has an order for [redacted] daily. The bottle to the medication is [redacted] tablets. The MAR notes [redacted] once daily, the MAR is incorrect.

Resident #2 has an order for [redacted] 1 capsule Monday and Thursday. The MAR notes 1.25mg capsules, the MAR is incorrect.

Plan of Correction ***Accept ([redacted] - 02/22/2023)***

The order for resident #2 OTC [redacted] was immediately changed in the electronic MAR to read take 2 - [redacted] tablets to equal 800 mg daily.

The OTC [redacted] error was immediately changed and the error was immediately reviewed with the appropriate staff and reviewed again 11/4/2022 at the staff nursing meeting.

187a - Medication Record (continued)

The staff were again re-educated that any OTC medication brought into the facility by family members must be reviewed with the DRC first before adding to the med cart to ensure the medication matches what was prescribed by the ordering physician.

The Med Manager and DRC will be responsible to do daily chart audits to ensure all medications are properly labeled and match appropriately. The Executive Director will ensure compliance.

The appropriate staff were re-educated 11/4/2022 on the OTC/CAM and proper documentation policy.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] 03/31/2023)

187d - Follow Prescriber's Orders

10. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 has an order for [redacted] 3 times daily hold for blood glucose less than [redacted]. On 10/12/22 at 8am the blood glucose was 120, the insulin was held and should have been administered.

On the following days the insulin was administered and should have been withheld: 10/17/22 at 5pm blood glucose was 104, 10/24/22 at 8am blood glucose was [redacted] 10/25/22 at 8am blood glucose was [redacted] and 10/26/22 at 5pm blood glucose was [redacted]

Repeat Violation: 10/14/21

Plan of Correction ***Accept [redacted] - 02/22/2023)***

The facility takes all medication administration extremely seriously and immediately reached out to a Certified Diabetic Instructor to come onsite to re-educate and train the unlicensed and licensed staff responsible for the administration of medication and monitoring or our diabetic residents.

The instructor was onsite 11/29/2022 - see the attached sign in sheet and credentials on the instructor

The DRC will be responsible to ensure all unlicensed staff and licensed staff are trained appropriately and will be responsible to ensure all prescribed orders are monitored and followed accurately by doing routine audits and spot checks on the med cart.

The Executive Director will be responsible to oversee compliance.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 03/31/2023)

227d - Support Plan Medical/Dental

11. 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

Resident #4 is receiving hospice services and utilizes a grab assist bar on the residents bed. The resident's RASP dated [redacted] has not been updated to reflect the residents current care needs.

Repeat Violation: 10/14/21

Plan of Correction ***Accept[redacted] - 02/22/2023)***

The DRC is new to the facility with a hire date of[redacted] and was in the process of auditing all resident file. When she was made aware the RASP was missing this information, she immediately updated the it.

There is a current process in place and all resident files will be reviewed quarterly with January being the first month to review files for compliance.

The Support Plan policy was reviewed with the DRC as well as the appropriate staff at the staff nurses meeting held 11-4-2023

The DRC will be responsible for creating and updating all RASP with the Executive Director overseeing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented[redacted] - 03/31/2023)

227g Support Plan Signatures

12. 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 #4's RASP dated[redacted] is not signed by the resident, or the residents inability or refusal to sign is not noted.

Plan of Correction ***Accept[redacted] - 02/22/2023)***

The DRC is new to the facility with a hire date of[redacted] and was in the process of auditing all resident file. When she was made aware the RASP wasn't properly signed she immediately updated the it.

There is a current process in place and all resident files will be reviewed quarterly with January being the first month to review files for compliance.
The Support Plan policy was reviewed with the DRC as well as the appropriate staff at the staff nurses meeting held 11-4-2023

The DRC will be responsible for creating and updating all RASP with the Executive Director overseeing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented[redacted] - 03/31/2023)

253c Records Log

13. Requirements

2600.
253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident's name, record number, birth date, admission date and discharge date.

Description of Violation

The home has destroyed resident records in the last 12 months. A log of the destroyed records was not kept by the home.

Plan of Correction ***Accept [redacted] - 02/22/2023)***

The Managing Operator/owner was in the process of selling the facility and was unaware of the regulation regarding destroy discharged files, and [redacted] destroyed very old files that were well beyond the 3 year regulation.

The Executive Director immediately had a tracking form created with all past and current residents of files that are currently on the premises and will document all discharges and any files destroyed.

The Administrative Assistant will be responsible for keeping track of all resident files with the Executive Director overseeing compliance.

see attached tracking form

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 03/31/2023)