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

January 23, 2023

[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 11/15/2022, 11/16/2022, 11/17/2022, 11/18/2022, 11/21/2022, 11/22/2022, 11/23/2022, 11/29/2022, 11/30/2022, 12/01/2022, 12/02/2022, 12/05/2022 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: *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**: [redacted] **Email**: [redacted]

Legal Entity

Name: *DRESHER CARE GROUP LLC*

Address: *1080 SW MOUNT BACHELOR DRIVE, SUITE 200, BEND, OR, 97702*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2019* **Issued By**: *Township of Upper Dublin*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *12/05/2022*

Inspection Dates and Department Representative

11/15/2022 - Off-Site: [redacted]
11/16/2022 - Off-Site: [redacted]
11/17/2022 - Off-Site: [redacted]
11/18/2022 - Off-Site: [redacted]
11/21/2022 - Off-Site: [redacted]
11/22/2022 - Off-Site: [redacted]
11/23/2022 - Off-Site: [redacted]
11/29/2022 - Off-Site: [redacted]
11/30/2022 - Off-Site: [redacted]
12/01/2022 - Off-Site: [redacted]
12/02/2022 - Off-Site: [redacted]
12/05/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Unit* **Capacity**: *59* **Residents Served**: *38*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *38*

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

Have Mobility Need: *38* **Have Physical Disability**: *0*

Inspections / Reviews

11/15/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2022*

12/28/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/23/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/02/2023*

01/09/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/23/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/12/2023*

01/10/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/23/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/12/2023*

01/23/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/23/2023*

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

According to the staff interviews, on [redacted], Resident #1 became physically aggressive with resident #2 while in the hallway. Resident #1 grabbed Resident #2 by the left arm and squeezed very hard. Staff members were able to release the resident's hands from resident 2 and they were separated. Resident #1 was moved into the living room and sat down in a chair. Resident #1 continued to be aggressive towards staff members and attempted to swing at them. Resident #1 then went to Resident #3 and grabbed them around the neck. It took multiple staff members to remove Resident #1 grip from resident #3. None of the residents sustained injuries. Resident #1 was then led to the activity room, where the resident began knocking over furniture and slamming it against the walls. Resident #1 was sent to [redacted] Hospital via 911. On [redacted], an [redacted] Hospital social worker called the facility to inform them that Resident #1 was ready to return, and staff member A informed them that Resident #1 was unable to return to the facility because the resident poses a safety risk to the other residents, and they did not have the capacity to provide the needed care. Staff member A informed resident #1's spouse the resident wouldn't be able to return to the facility given because of the resident's aggressive and combative behavior.

Resident #1 has a history of aggressive behavior. On [redacted], Resident #1 was combative towards staff members, walking up to them and grabbing them. On the same day, resident# 1 was observed being aggressive with another resident. The resident gripped Resident 4 by the forearms, and staff members separated them. There were no reported injuries. Following that incident, Resident #1 picked up a chair and attempted to throw it at staff members in the dining /activity room area. A Staff member pried the chair from the resident's hands and sat the resident in a chair. Resident #1 was sent to [redacted] Hospital for evaluation. On [redacted]2, Resident #1 was observed fighting with another resident. The resident is difficult to redirect. Resident #1 was sent to [redacted] Hospital for evaluation.

Plan of Correction ***Accept (MJ - 01/09/2023)***

Resident #1 was immediately separated from others and supervised. Family and physician notified. 911 called for eval at hospital for BHU stay
Staff will immediately report any resident with potential aggressive behaviors to DON/ED
PCP will be notified for eval and referral to psych practitioner
In the event 1:1 is the preferred intervention; family will be notified that this will be required 24 hours daily.
If scheduled 1:1 caregiver is not in attendance, a staff member will be assigned to the resident until arrival and family will be notified.
DON/designee will ensure appropriate documentation of interventions and responses, along with updating RASP as required.
Staff will be reeducated by DON on regulation 42b (abuse). Education to be completed by 12/28/22 (Paper to follow)
All information will be reviewed by ED at quarterly QA

Licensee's Proposed Overall Completion Date: *01/02/2023*

Implemented (MJ - 01/23/2023)

201 - Positive Interventions

2. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

According to the staff interviews, on [redacted] early in the morning and before 8am, Resident #1 became physically aggressive with Resident #2 while in the hallway. Resident #1 grabbed Resident #2 by the left arm and squeezed very hard. Staff members were able to release the resident's hands from resident 2, and they were separated. Resident #1 was moved into the living room and sat down in a chair. Resident #1 continued to be aggressive towards staff members and attempted to swing at them. Resident #1 then went to Resident #3 and grabbed them around the neck. The assessment and support plan notes for Resident 1 dated [redacted] indicated the Resident #1's family began providing one-on-one care on that date, from 8:00 a.m. to 8:00 p.m. However, the resident did not have 1-1 during the early morning [redacted] The home did not use positive interventions to modify or eliminate the behavior that endangered the resident or others from the moment that the resident got up in the morning until 8:00 a.m., when the Resident 1's family arrived at the facility to provide 1-1 supervision.

Plan of Correction ***Accept (MJ - 01/09/2023)***

Resident #1 was immediately separated from others and supervised by staff. Family and physician notified. 911 called for eval at hospital for BHU stay
Staff will immediatelty report any resident with potential aggressive behaviors to DON/ED
PCP will be notified for eval and referral to psych practitioner
In the event 1:1 is the preferred intervention; family will be notified that this will be required 24 hours daily.
If scheduled 1:1 caregiver is not in attendance, a staff member will be assigned to the resident until arrival and family will be notified.
DON/designee will ensure appropriate documentation of interventions and responses, along with updating RASP as required.
Staff will be reeducated on regulation 201 (safe management techniques) by DON completed by 12/28/22 (Paper to follow)
All information will be reviewed by ED at quarterly QA

Licensee's Proposed Overall Completion Date: *01/02/2023*

Implemented (MJ - 01/23/2023)