

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

March 13, 2023

[REDACTED], EXECUTIVE DIRECTOR
WOODS SERVICES, INC.

RE: BEECHWOOD CENTER 4
586 BEECHWOOD CIRCLE
LANGHORNE, PA, 19047
LICENSE/COC#: 12966

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/20/2022 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: BEECHWOOD CENTER 4 License #: 12966 License Expiration: 11/01/2023
Address: 586 BEECHWOOD CIRCLE, LANGHORNE, PA 19047
County: BUCKS Region: SOUTHEAST

Administrator

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

Legal Entity

Name: WOODS SERVICES, INC.
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other Date: 08/29/1984 Issued By: Township of Middletown

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 12 Waking Staff: 9

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 12/20/2022

Inspection Dates and Department Representative

12/20/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 8 Residents Served: 8

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 6 Are 60 Years of Age or Older: 4
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 4 Have Physical Disability: 4

Inspections / Reviews

12/20/2022 Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/16/2023

01/19/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 02/28/2023
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/24/2023

Inspections / Reviews *(continued)*

01/26/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/28/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 02/28/2023

03/13/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/28/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

The home does not have a certificate on file that shows that direct care staff person A, hired on [REDACTED], completed the Department-approved direct care training course and passed the competency test before providing unsupervised ADL services.

Repeated Violation: 9/14/21

Plan of Correction

Accept [REDACTED] - 01/26/2023)

• An audit of DHS certificates was completed on the home by the Director of Licensing on 1/11/23 and all other staff certificates are present.

Staff A to not complete ADL services unsupervised until completion of DHS training course. Upon Inquiry, staff provided a copy of her certificate demonstrating completion of the course upon hire 12/18/19.

• To ensure future completion of the DHS training course for all new employees, the class has been included in the new hire orientation provided by Woods Training Department starting on 11/14/22. Director of Licensing and Accreditation to obtain copy of certificate to ensure completion prior to the new hire starting in the home.

Licensee's Proposed Overall Completion Date: 01/24/2023

Implemented [REDACTED] - 03/13/2023)

85a - Sanitary Conditions

2. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED] at [REDACTED] AM, the Jack & Jill bathroom shared by the residents in room #9 and #10 had a strong smell of urine.

Plan of Correction

Accept [REDACTED] - 01/26/2023)

Housekeeping was assigned to complete a deep cleaning of identified bathroom on 1/10/23 and a review of the importance of daily upkeep was done by the Personal Care Home Administrator. Starting on 1/13/23, spot checks/rounds will be completed by the Personal Care Home Administrator when in the home at least once a week for 3 months to ensure continued cleanliness of the bathroom.

Licensee's Proposed Overall Completion Date: 01/24/2023

Implemented [REDACTED] - 03/13/2023)

86b - Bathroom

3. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

86b Bathroom (continued)

Description of Violation

The Jack & Jill bathroom between resident room #2 & #3 does not have a window and the ventilation fan is not working.

Plan of Correction

Accept () - 01/26/2023

A request was submitted by the Personal Care Home Administrator to maintenance on 1/11/23 to have the fan repaired. Anticipated resolution date 1/25/23. The fan has been repaired and is now in working order. All other fans were inspected to ensure function on the date of inspection 12/20/22. The Personal Care Home Administrator will check the fans for functionality during the monthly environmental checks starting on 2/1/23.

Licensee's Proposed Overall Completion Date: 01/24/2023

Implemented () - 03/13/2023

132a - Monthly Fire Drill

4. Requirements

2600. 132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of March 2022.

Plan of Correction

Accept () - 01/26/2023

During a previous audit, the missing fire drill was identified. To ensure compliance with this standard and to prevent recurrence, the monthly fire drills are completed and submitted by the Personal Care Home Administrator to the Assistant Director. The Assistant Director or designee will be responsible to follow up with the Personal Care Home Administrator when a drill has not been submitted by the 20th of each month to ensure that it is completed by the end of the month. Procedure was implemented on 10/14/22.

Licensee's Proposed Overall Completion Date: 01/24/2023

Implemented () - 03/13/2023

132b - Safety Inspection/Fire Drill

5. Requirements

2600. 132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not have a fire drill observed by a fire safety expert in the year 2021.

Plan of Correction

Accept () - 01/19/2023

An observed fire drill and fire safety inspection was completed on 6/8/21. Requests to the inspector were unsuccessful to show supporting documentation of completion. An observed fire drill and fire safety inspection was completed on 6/3/22 and documentation was provided. The Director of Licensing will be responsible to schedule observed fire drills and fire safety inspections annually to meet the regulatory standard 2600.132.b. A standing annual reminder is set for 5/1/22 for the Director to contact

132b - Safety Inspection/Fire Drill (continued)

the fire safety expert and schedule the drills.

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

Implemented [redacted] - 03/13/2023)

141a - Medical Evaluation

6. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1 was admitted to the home on [redacted]. However, the medical evaluation was not completed within 60 days prior to admission or within 30 days after admission of the resident. The one on file was dated [redacted].

Plan of Correction

Accept ([redacted] - 01/19/2023)

• To ensure that all documentation is completed when transfers occur between homes, an internal transfer checklist tool was created for the Care Coordination team to use. The internal transfer checklist has been in place since August 2022. It is utilized by the Care Coordination team each time a participant transfers from one residence to another. The Care Coordination team is comprised of a Director of Care Coordination and Four Care Coordinators. • The Director of Care Coordination met with the Care Coordinators on 11/8/22 to train them on the use of the tool to ensure thorough completion of documentation.

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

Implemented [redacted] - 03/13/2023)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's medical evaluations dated [redacted] did not include (8) Body positioning and movement stimulation.

Plan of Correction

Accept ([redacted] - 01/19/2023)

To ensure thoroughness of all resident medical evaluations, the assigned Beechwood nurse will review all evaluations prior to being sent to records. As an additional check, the records specialist will review the medical evaluation

141a 1 10 Medical Evaluation Information (continued)

before uploading into the electronic record. Should any information be found missing the doctor will be notified of the incomplete form. This procedure will begin on 1/17/23.

Licensee's Proposed Overall Completion Date: 01/17/2023

Implemented () - 03/13/2023)

141b1 - Annual Medical Evaluation

8. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Plan of Correction

Accept () - 01/19/2023)

The late Annual Medical Evaluation was discovered by the Nursing Department following the visit. • A tracking system was implemented for the 2022 year for the Medical Scheduler to ensure that the Medical Evaluations are completed annually. The annual dates are maintained on a spreadsheet and referenced by the Medical Scheduler weekly to ensure that the timeline is met. This tracking system does not have an end date to its use. • Resident #3's most recent medical evaluation was completed on 1/5/23.

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

Implemented () - 03/13/2023)

185a - Implement Storage Procedures

9. Requirements

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

On [REDACTED] at [REDACTED] PM, resident #4's blood glucose level was [REDACTED] (on the resident's glucometer) while the log read 223.

Plan of Correction

Accept () - 01/19/2023)

Nursing staff responsible for scanning and documenting the glucometer readings will be re trained by the AVP of Nursing Services on 1/17/23
• The Nursing Manager will complete weekly checks/reviews of the documentation and glucometer readings starting 1/16/23 for at least three months to ensure that the nursing staff are accurately implementing the glucometer procedures.
• After 3 months of weekly monitoring (Week of 4/17/23) the AVP of Nursing Services will review the reports submitted at the end of each month and determine if monitoring can taper to monthly.

Licensee's Proposed Overall Completion Date: 01/17/2023

Implemented () - 03/13/2023)

187a - Medication Record

10. Requirements

2600.

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

6. Dose.

Description of Violation

Resident #4 is prescribed insulin injections based on a sliding scale. However, the resident's December medication administration record (MAR) does not indicate the insulin units given.

Plan of Correction

Accept () - 01/26/2023

Upon review of Resident #4's MAR the documentation of the insulin units given was present. Nursing responsible for using the electronic MAR and documentation system will be trained by the AVP of Nursing Services for how to access insulin data within the electronic MAR on 1/17/23.

EMR access to insulin reports have been added as a standing monthly meeting agenda item, held by the Nursing Manager, for nursing staff starting on 1/23/23.

Licensee's Proposed Overall Completion Date: 01/24/2023

Implemented () - 03/13/2023

187d - Follow Prescriber's Orders

11. Requirements

2600.

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

Description of Violation

Resident #4 is prescribed insulin injections based on a sliding scale. The resident's blood glucose level was () on () at () PM, requiring 6 units of insulin in addition to his standing order. However, the resident's December MAR reads (), requiring 4 units.

Plan of Correction

Accept () - 01/19/2023

Nursing staff responsible for scanning and documenting the glucometer readings will be re-trained by the AVP of Nursing Services on 1/17/23

• The Nursing Manager will complete weekly checks/reviews of the documentation and glucometer readings starting 1/16/23 for at least three months to ensure that the nursing staff are accurately implementing the glucometer procedures.

• After 3 months of weekly monitoring (Week of 4/17/23) the AVP of Nursing Services will review the reports submitted at the end of each month and determine if monitoring can taper to monthly.

Licensee's Proposed Overall Completion Date: 01/17/2023

Implemented () - 03/13/2023

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 #5's assessment/support plan dated () was not signed by the assessor.

227g Support Plan Signatures (continued)

Plan of Correction

Accept [redacted] - 01/26/2023)

On 1/10/23, Director of Care Coordination held a training with the Care Coordination team to review the proper completion of the Residential Assessment and Support Plan. The applicable 2600 regulations were reviewed in detail and the importance of obtaining applicable signatures was stressed. Scenarios and reviews of RASP's were utilized as teaching tools and performance improvement measures to help the team improve their understanding of the information that should be included in the RASP. Steps for obtaining signatures were reviewed as follows:

Step 1 Care Coordinator completes the RASP with input from the residential staff and treatment team.

Step 2 The RASP is reviewed at the Rehabilitative Support Plan (RSP) meeting with the participant and treatment team.

Step 3 Signatures are obtained on the RASP at the time of the meeting.

If the RASP is a significant change or does not coincide with a treatment team meeting, the Care Coordinator will obtain signatures when meeting with staff members and the participant upon completion of the document in the home. Starting in January 2023 quarterly audits will be completed by the Director of Care Coordination and the Care Coordinators of a sampling of resident records for thoroughness. The audit goal is to reach a minimum of 20% of the records annually and will be under the responsibility of the Director of Care Coordination.

Licensee's Proposed Overall Completion Date: 01/24/2023

Implemented [redacted] - 03/13/2023)