

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

March 24, 2023

[REDACTED]
NORTH WALES 1091 PCH BG OPCO LLC
[REDACTED]
[REDACTED]

RE: PARK CREEK PLACE - PERSONAL
CARE
1091 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14257

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/09/2023 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: *PARK CREEK PLACE - PERSONAL CARE* License #: *14257* License Expiration: *01/30/2024*
 Address: *1091 HORSHAM ROAD, NORTH WALES, PA 19454*
 County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *NORTH WALES 1091 PCH BG OPCO LLC*
 Address: *330 N WABASH AVENUE,SUITE 3700, CHICAGO, IL, 60611*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *04/28/1999* Issued By: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *56* Waking Staff: *42*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *01/09/2023*

Inspection Dates and Department Representative

01/09/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *72* Residents Served: *41*
Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:
Hospice
 Current Residents: *2*
 Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *41*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *15* Have Physical Disability: *0*

Inspections / Reviews

01/09/2023 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/27/2023*

01/31/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *03/24/2023*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *02/03/2023*

Inspections / Reviews *(continued)*

03/24/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/24/2023

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

On 1/9/2023, the hot water temperature in room [REDACTED] measured 122.7 degrees Fahrenheit.

On 1/9/2023, the hot water temperature in room [REDACTED] measured 122.5 degrees Fahrenheit.

On 1/9/2023, the hot water temperature in room [REDACTED] measured 123.4 degrees Fahrenheit.

On 1/9/2023, the hot water temperature in room [REDACTED] measured 122.5 degrees Fahrenheit.

Plan of Correction

Accept (MJ - 01/31/2023)

On 1.9.23 the Maintenance Technician lowered the temperature of the hot water heater from 122 to 120 degrees Fahrenheit.

- On 1.9.23, the Maintenance Technician reevaluated the hot water temperature in resident rooms, including rooms, [REDACTED], and [REDACTED], water temperatures were within 118 to 120 degrees Fahrenheit. This was completed in the presence of auditor and corrected on site of audit.
- On 1.24.23, the Maintenance Technician audited the water temperature of the home's rooms and validated that temperatures were within the regulated range (Exhibit -AAA1)
- On 1.25.23 the Regional Director of Facilities Management (RDFM) educated the Executive Director (ED) and Maintenance Technician on the requirements set within 2600.89b (Exhibit AAA2 – In-service)
- Beginning, the Maintenance Technician will evaluate the hot water temperature in 5 resident rooms to ensure the hot water temperatures remain within the regulated range weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit AAA3 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1.25.23.

See attached.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented (MJ - 03/24/2023)

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

On 1/9/2023, the enabler bed bar with a 6" opening on resident 1's bed does not have a cover.

Plan of Correction

Accept (MJ - 01/31/2023)

On 1.19.23 the Care Services Manager (CSM) placed a cover over Resident #1's bed enabler.

- On 1.19.23 the CSM audited bed enabler bars within the home to validate the presence of a cover. Enabler bars that were identified to be uncovered, were then covered. (Exhibit BBB1– Audit Tool)
- On 1.18.23 the CSM educated current direct care staff on the requirements set within regulation 2600.95. (Exhibit BBB2- In-service)
- Beginning 1.23.23, the CSM or designee will audit 3-bed enabler bars within the home weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit BBB3- Audit Tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1.19.23. See attached.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (MJ - 03/24/2023)

183b - Meds and Syringes Locked

3. 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

On 1/9/2023, Refresh Eye drops, Afrin Nasal Spray, and AYR Saline nasal spray were unlocked, unattended, and accessible in the bathroom of Resident 1's room.

Plan of Correction

Accept (MJ - 01/31/2023)

On 1.9.23 the CSM secured Resident #1's Refresh Eye Drops, Afrin Nasal Spray, and AYR spray.

- On 1.19.23 the CSM conducted a Self-Medication Assessment on Resident #1. (Exhibit CCC 1-Assessment)
- On 1.19.23 the CSM educated Resident #1 on the requirements of 2600.183b. Resident #1 verbalized understanding.
- On 1.19.23 the CSM audited the apartments of additional residents within the home who self-administer their medications. No additional unsecured medications were identified. (Exhibit CCC 2 – Audit Tool)
- On 1.18.23 the CSM educated the current staff on the requirements set within regulation 2600.183b and Enlivant Policy, "Self-Administering Medications Policy". (Exhibit CCC 3 -Audit Tool)
- Beginning 1.23.23 the CSM or designee will audit the apartments of the residents that self-administer their medications weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit CCC 4- Audit Tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1.20.23.

183b - Meds and Syringes Locked (continued)

See attached.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented (MJ - 03/24/2023)

183d - Prescription Current**4. Requirements**

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 1/9/2023, resident 1 had the following OTC medications in their bathroom AYR Saline Nasal Spray, Afrin Nasal Spray, and Refresh eye drops. These medications are not currently prescribed to the resident and were not included on the residents Medication administration record.

Plan of Correction

Accept (MJ - 01/31/2023)

On 1.9.23 the CSM obtained a Physician order for Resident #1 for AYR Saline Nasal Spray, Afrin Nasal Spray, and Refresh eye drops. These medication orders were subsequently transcribed to Resident #1's Medication Administration Record. (Exhibit DDD 1 – Orders)

- On 1.9.23 Resident #1 was educated on the requirements set within regulation 2600.183d and verbalized understanding.
- On 1.20.23 the CSM audited the apartments of current residents for unprescribed medications. No additional unprescribed medications were identified. (Exhibit DDD 2 – Audit Tool)
- On 1.9.23 & 1.18.23 the CSM educated currently employed medication technicians and licensed nurses on the requirements set within regulation 2600.183d. (Exhibit DDD 3 – In-service)
- Beginning 1.25.23 the CSM or designee will audit 5 resident apartments for the presence of unprescribed medications weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit DDD 4- Audit Tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1.20.23.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (MJ - 03/24/2023)

185a - Implement Storage Procedures**5. 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 1/9/2023, at 4:00 pm, staff person A left the Medication cart unlocked, unattended in the presence of the Department's Representative. Staff person A did not return to the cart until 4:10 pm.

On 1/9/2023, at 4:00 pm, the glucometer belonging to resident 2 was not calibrated correctly. The date shown on the meter was July 6 and the time was 11:32 pm.

185a - Implement Storage Procedures (continued)

Plan of Correction**Accept (MJ - 01/31/2023)**

On 1.9.23, upon returning to the medication cart, Staff Person A locked the medication cart.

- On 1.18.23, the CSM educated Staff Person A on the requirements set within regulation 2600.185a and Enlivant Policy titled, "Medication Administration Policy". (Exhibit EEE 1 – Audit Tool)
- On 1.24.23, The CSM observed Staff Person A during a medication pass while conducting a medication observation and competency checklist. (Exhibit EEE 2 – Checklist)
- On 1.19.23, the CSM educated the homes currently employed Medication Technicians and Licensed Nurses on the requirements set within Regulation 2600.185a and Enlivant policy titled, "Medication Administration Policy". (Exhibit EEE 3 – In-service)
- By 1.18.23, the CSM will observe the home's currently employed Medication Technicians and Licensed Nurses during a medication pass to conduct a medication observation and competency checklist. (Exhibit EEE 4 – Audit Tool)
- Beginning 1.19.23, the CSM or designee will observe an unattended medication cart to ensure that it is locked, 3 x per week x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit EEE 5- Audit Tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1.9.23.
- On 1.19.23, the CSM calibrated Resident #2's glucometer to the current date and time.
- On 1.18.23, The CSM educated the homes currently employed Medication Technicians and Licensed Nurses on the requirements set within Regulation 2600.185a (Exhibit FFF 1 – In-service)
- On 1.19.23, the CSM audited current resident glucometers, calibrating them if needed to reflect the current date and time. (Exhibit FFF 2 – Audit Tool)
- Beginning 1.23.23, the CSM or designee will audit current resident glucometers to ensure that they are calibrated to the current date and time weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit FFF 3- Audit Tool)

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (MJ - 03/24/2023)

227d - Support Plan Medical/Dental

6. 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

The assessment for resident 1, dated [REDACTED], indicates the resident has a need for toileting. The degree of need has not been indicated on the residents support plan.

Plan of Correction**Accept (MJ - 01/31/2023)**

- On 1.9.23 the Assistant Care Services Manager (ACSM) updated Resident #1s support plan dated [REDACTED], to reflect the residents' degree of need for assistance with toileting. (Exhibit GGG 1- Support Plan Addendum)

227d - Support Plan Medical/Dental (continued)

- On 1.9.22 the CSM educated the ACSM on the requirements set within Regulation 2600.227d (Exhibit GGG 2- In-Service)
- By 1.19.23, the CSM and ACSM will audit current resident support plans to ensure residents requiring assistance with Activities of Daily Living (ADLs) have a corresponding degree of assistance. Support plans identified with omitted degrees of assistance will be updated by the CSM or ACSM accordingly. (Exhibit GGG 3- Audit Tool)
- Beginning 1.23.23, the CSM or designee will audit 3 resident support plans weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1 to ensure support plans reflect a resident's required degree of assistance. (Exhibit GGG 4- Audit Tool)
- The QI committee will determine if continued auditing is necessary based upon three consecutive months of compliance.
- Completion date 1.9.23.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (MJ - 03/24/2023)

251b - Record Entries Legible

7. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident 2's Medication Administration Record has multiple scribbled out entries that are illegible and unclear.

Plan of Correction

Accept (MJ - 01/31/2023)

On 1.10.23, the CSM audited the current months' MARs to self-identify additional illegible entries. No additional illegible entries were identified. (Exhibit HHH 1 – Audit Tool)

- *On 1.18.23 the CSM clarified the previously noted illegible documentation with the author, a med tech, and validated that the med-tech subsequent documentation related to the initial illegible entry was legible on the MAR.*
- *On 1.18.23, the CSM educated the homes currently employed Medication Technicians and Licensed Nurses on the requirements set within Regulation 2600.251b and Enlivant policy titled, "Medication Documentation Policy". (Exhibit HHH 2 – In-service)*
- *By 1.18.23, the CSM will observe the home's currently employed Medication Technicians and Licensed Nurses during a medication pass to conduct a medication observation and competency checklist. (Exhibit HHH 3 – Audit Tool)*
- *Beginning 1.23.23, the CSM or designee will audit the current months' MAR for illegible entries once per week x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit HHH 4- Audit Tool)*
- *The QI committee will determine if continued auditing is necessary based upon three consecutive months of compliance.*
- *Completion date 1.10.23.*

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (MJ - 03/24/2023)