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

March 16, 2023

[redacted] ED
GREENFIELD OF PERKIOMEN VALLEY LLC
125 NORTH WASHINGTON STREET
FALLS CHURCH, VA, 22046

RE: GREENFIELD OF PERKIOMEN VALLEY
300 PERKIOMEN AVENUE
SCHWENKSVILLE, PA, 19473
LICENSE/COC#: 13735

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/19/2023 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: *GREENFIELD OF PERKIOMEN VALLEY* **License #**: *13735* **License Expiration**: *08/09/2023*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *99* **Waking Staff**: *74*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *01/19/2023*

Inspection Dates and Department Representative

01/19/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *66*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Willow* **Capacity**: *20* **Residents Served**: *14*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

01/19/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/11/2023*

02/22/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/15/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/26/2023*

Inspections / Reviews *(continued)*

02/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/15/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/24/2023*

03/16/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/15/2023*

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

16c Written Incident Report

1. 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] at [redacted] resident 1 had an unwitnessed fall in their room. The resident was sent [redacted] hospital where they received staples in the back of their head. The home did not report this incident to the department until [redacted] at [redacted].

On [redacted] at [redacted] resident 2 had a fall and was sent to [redacted] hospital where they were diagnosed with a left hip fracture and received staples in the back of their head. The home did not report this incident to the department until [redacted] at [redacted].

Repeat Violation Date: 2/15/22 et al.

Plan of Correction ***Accept ([redacted] - 02/17/2023)***

Beginning 1/20/2023, all incidents shall be reported within 24 hours of the incident. Jarrice Jones, Healthcare Coordinator, will be trained by 2/28/2023 on how to complete a reportable and educated on submitting reportable within 24 hrs. If [redacted] is not available [redacted], ED will submit the reportable within 24hrs.
All staff members will receive training on timely incident reporting at the next all staff in service scheduled for __2/23/2023____.

Licensee's Proposed Overall Completion Date: *03/15/2023*

Implemented [redacted] - 03/16/2023)

42b Abuse

2. 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

On [redacted] when the secure dementia care unit(SDCU) morning shift arrived, they found resident 3 sleeping on the couch. When resident 3 was assisted into a wheelchair, urine leaked from their overly saturated brief. Resident 3's support plan shows that they require some physical assistance for toileting, bladder management, and bowel management.

On [redacted], when morning shift arrived the found, Resident 4, who was also sitting on the couch. When resident 4 stood up, urine leaked from their oversaturated brief and dripped down their leg.

On [redacted],during the morning shift, it was observed by the staff that Resident 5 had not been changed from their clothes that they wore on the previous day.

On [redacted], Residents 6 and 7 were found by the morning shift staff, to be soaked with urine in their beds having not received incontinence care during the overnight shift. Both residents require physical assistance with toileting

42b Abuse (continued)

The resident toileting list indicates that residents are to be checked every two hours and initialed by staff. Review of the resident toileting list for the SDCU for the 1/18/23 11pm to 7am overnight shift shows that 7 residents, including resident 1, 2, 4, 6, and 8, who need physical/assist for toileting were not checked on after midnight by the overnight shift until the morning shift began checking on residents after 7am on 1/19/23.

Plan of Correction ***Accept (- 02/27/2023)***

In service training provided to employees 2/3/2023 on the importance of documentation and providing incontinence care. Staff coming on the shift will do spot check every morning for all residents in memory care with staff coming off the shift.
Beginning 1/20/2023 the Memory Care Coordinator will do spot checks twice a week in the morning and select random resident to make sure they are not saturated.
Beginning 1/20/2023 Memory Care Coordinator will check Activities of Daily Living sheets daily to make sure toileting has been sign off on. When the memory care coordinator is not at work the resident care coordinator will fill in.
The Home does not agree with the Departments finding of abuse and completing the plan of correction is not an admission of guilt or acceptance of this violation.
Abuse and neglect training provided to all staff and be completed by Power Physical therapy.

Licensee's Proposed Overall Completion Date: *03/13/2023*

Implemented (- 03/16/2023)

82c - Locking Poisonous Materials

3. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted] at [redacted] in room [redacted] in the secure dementia care unit, there was a tube of crest toothpaste, bottle of CVS mouthwash, and canister of disinfecting wipes, with a manufacture's label indicating contact poison control if swallowed, were unlocked, unattended, and accessible to residents. Not all the residents of the home, including resident 3, have been assessed capable of recognizing and using poisons safely.

Repeat Violation date: 5/17/22 et al.

Plan of Correction ***Accept (- 02/21/2023)***

On 1/19/2023 the identified items were removed and locked securely by direct care staff.
Beginning 1/20/2023 Staff on duty will provide room checks during their shift and sign off that resident room doesn't have any poisonous material easily accessible to resident. Documentation of room checks shall be kept by the Memory Care Coordinator.
Additionally, beginning 1/20/2023, Memory care coordinator will do room checks daily to make sure no poisonous supplies has been left out.
All staff will receive training on proper storage and security of all items that are labeled as poisonous at the next all staff meeting scheduled 2/23/2023.

Licensee's Proposed Overall Completion Date: *03/15/2023*

Implemented (- 03/16/2023)

82c Locking Poisonous Materials *(continued)*

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/19/23 at 9:40AM, there is a sticky substance scattered around the interior of the Secure dementia care unit(SDCU) Freezer.

On 1/19/23 at 9:51AM, the floor of the walk in fridge in the main kitchen had a substantial area of grime, and other accumulated debris as well as a pool of brownish liquid present under the metal shelving rack.

Plan of Correction ***Accept [redacted] - 02/21/2023)***

The spill in the Memory Care freezer and main walk in was cleaned by Dining service staff on 1/19/2023.
Beginning 1/20/2023, Dining service staff will be responsible for checking the memory care fridge and freezer daily for spills and provide cleaning as needed when they deliver meals to memory care.
The dietary department will conduct a deep clean of the main kitchen, food storage areas and walk in fridge and freezer on 2/6/2023
A daily Kitchen cleaning program was introduced on 2/6/2023 and will be monitored and enforced by the Dining Service Director weekly.
Beginning 1/20/2023, the Memory Care Director or designee shall inspect the Memory Care food service and storage areas weekly for cleanliness and potential unsanitary conditions.

Licensee's Proposed Overall Completion Date: *03/15/2023*

Implemented [redacted] - 03/16/2023)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 3, in room [redacted] does not have access to a source of light that can be turned on/off at bedside.

Repeat Violation Date: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 02/21/2023)***

On 1/19/2023 a light source was place by resident #3s bed that can be operated at bedside by the Maintenance Assistant.
The Maintenance Department will inspect every occupied room by 2/28/2023 to ensure they have a working light source that is operable at bedside. Documentation shall be kept.
Beginning 3/1/2023 the homes housekeeping staff will be responsible for checking the bedside lights as they clean resident rooms as part of their cleaning schedule.

Licensee's Proposed Overall Completion Date: *03/15/2023*

Implemented ([redacted] - 03/16/2023)

103i - Outdated Food

6. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 1/19/23 at 9:48AM, there are 2 open bags of cake mix and an open bag of pecans in dry food storage without an opened on:" date.

Repeat Violation Date: 5/17/22 et al.

Plan of Correction ***Accept (- 02/21/2023)***

The identified items were discarded on 1/19/2023 by the dietary staff.
All dietary staff shall be retrained on proper labeling, dating and storage of food items by the Dining Services Director of 2/28/2023. Documentation shall be kept.
Beginning 1/20/2023, the Dining Services Director or designee shall inspect the food storage areas daily to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/15/2023*

Implemented (- 03/16/2023)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 1/19/23 at 9:30AM, the emergency egress from Willow unit to Willow stairwell was locked. There is no code or keypad system for the door to release and the door did not release on delay.

Plan of Correction ***Accept (- 02/27/2023)***

The Maintenance Coordinator has reached out to Fusion factors and ordered a delayed Egress Magnetic Door Lock and will be installed thereafter. The exit sign has been reinstalled on the door.

Licensee's Proposed Overall Completion Date: *03/10/2023*

Implemented (- 03/15/2023)

233c - Key-Locking Devices

8. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 1/19/23 at 9:26AM, The directions for operating the home's locking mechanism are not conspicuously posted near the courtyard gate to the Secure Dementia Care Unit (SDCU).

233c - Key-Locking Devices (continued)

Additionally, on 1/19/23 the emergency egress door from the Willow Unit to the Willow Stairwell is locked and does not open with a delayed release push bar. There are no signs posted on how to unlock/open this door in the event of an emergency.

Repeat Violation Date: 5/17/22 et al.

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

A new sign with the code was posted at the memory care courtyard gate by the Maintenance Department on 1/20/2023.
Beginning 1/20/2023 The Memory care Director will check all Memory Care exits, weekly, to ensure the current code is posted and egress is not permanently impeded.
All staff shall be trained on ensuring that egress routes are not locked, blocked or impeded unless they are part of the approved delayed locking mechanism at the next all staff meeting scheduled for 2/23/2023

Licensee's Proposed Overall Completion Date: *03/15/2023*

Implemented ([redacted] - 03/15/2023)

234b - Support Plan Needs Elements

9. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated [redacted], for resident 4 does not address toileting, bladder management, and bowel management. Staff interviews reported that resident 4 has incontinence issues. The resident toileting sheet list resident 4 as a physical/assist for toileting.

The support plan, dated [redacted], for resident 8, does not address that 2 people are needed to assist resident 8 in transferring in and out of bed/chair and for ambulating. Staff interviews reported that resident 8 is a 2-person assist.

Plan of Correction ***Accept [redacted] - 02/21/2023)***

The RASP for both identified resident has been updated by the MemoryCare Coordinator on [redacted] to reflect their care level.
Beginning 3/1/2023. The MemoryCare Coordinator, HealthCare Coordinator and ED will meet once a month to discuss the residents care needs and whether their RASPs need to be updated to reflect changing care needs.
The MemoryCare Coordinator will then update the RASPs as needed and discuss with the resident and responsible parties.
Lastly, the MemoryCare Coordinator will update the ADL sheets to ensure change in care is communicated to direct care staff.

Licensee's Proposed Overall Completion Date: *03/15/2023*

Implemented ([redacted] - 03/16/2023)