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

February 22, 2023

[redacted]
SPRINGFIELD PCH LLC
[redacted]

RE: SPRINGFIELD CROSSINGS
463 WEST SPROUL ROAD
SPRINGFIELD, PA, 19064
LICENSE/COC#: 14651

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/01/2023 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**: *SPRINGFIELD CROSSINGS* **Licen e #**: *14651* **Licen e Expiration**: *04/14/2023*

**Address**: *463 WEST SPROUL ROAD, SPRINGFIELD, PA 19064*

**County**: *DELAWARE* **Region**: *SOUTHEAST*

## Administrator

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

## Legal Entity

**Name**: *SPRINGFIELD PCH LLC*

**Address**: [redacted]

**Phone**: *6105442200* **Email**: *astevens@springfieldcrossings.com*

## Certificate(s) of Occupancy

## Staffing Hours

**Resident Support Staff**: *102* **Total Daily Staff**: *190* **Waking Staff**: *143*

## Inspection Information

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

**Reason**: *Provisional, Monitoring* **Exit Conference Date**: *02/01/2023*

## Inspection Dates and Department Representative

*02/01/2023 On Site* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *84* **Residents Served**: *64*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents**: *8*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *64*

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

**Have Mobility Need**: *24* **Have Physical Disability**: *0*

# Inspections / Reviews

### 02/01/2023 - Partial

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/13/2023*

### 02/08/2023 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *02/22/2023*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/13/2023*

## Inspections / Reviews *(continued)*

**02/14/2023** - **POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *02/22/2023*

**Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/07/2023*

**02/22/2023** - **Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *02/22/2023*

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

## 65f - Training Topics

**1. Requirements**

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

**Description of Violation**

*Direct care staff person A did not receive training in meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2022.*

**Plan of Correction** ***Accept [redacted] - 02/14/2023)***

*A. With respect to the specific resident or event cited.*

- *Direct care staff person A did not receive training in meeting the needs of the residents as described in the preadmssion screening form, assessment tool, medical evaluation, and support plan during the training year 2022.*

*B. With respect to what systemic measures have been put in place to address the stated concern.*

- *The direct care annual training plan has been updated on 2/4/2023 to ensure all required training topics listed in 2600.65.f. are completed annually.*
- *It is the responsibility of the DHW and/or Executive Director to ensure direct care staff completes the training as assigned through the Relias training, and/or in-person training.*
- *Staff person A to be trained during the next scheduled in-service on 2/16/23.*

*C. With respect to how the plan of corrective measures will be monitored.*

- *A new DHW and ED have been hired and will verify the annual training plan for ongoing compliance. DHW will audit completion of training monthly x 3 months and will then continue with random checks.*

*Please see attached 2023 training plan.*

**Licensee's Proposed Overall Completion Date:** *02/09/2023*

***Implemented [redacted] 02/22/2023)***

## 65g - Annual Training Content

**2. Requirements**

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

**Description of Violation**

*Staff person A did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2022.*

**Plan of Correction** ***Accept [redacted] 02/14/2023)***

*A. With respect to the specific resident or event cited.*

- *Direct care staff person A did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during the training year 2022.*

*B. With respect to what systemic measures have been put in place to address the stated concern.*

- *The direct care annual training plan has been updated to ensure all required training topics listed in 2600.65.f. are completed annually for 2023.*

## *65g - Annual Training Content (continued)*

- *The annual staff training plan updated on 2/4/2023 to ensure all required training topics listed in 2600.65.g. are completed annually.*
- *Staff person A to be trained during the next scheduled in-service on 2/16/2023.*
- *t is the responsibility of the DHW and/or Executive Director to ensure direct care staff completes the training as assigned through the Relias training and/or in-person training.*

*C. With respect to how the plan of corrective measures will be monitored.*

- *A new DHW and ED have been hired and will verify the annual training plan content for ongoing compliance.*
- *DHW will audit completion of training monthly x3 months and will then continue with random checks.*

*Please see attached 2023 training plan.*

**Licensee's Proposed Overall Completion Date:** *02/09/2023*

***Implemented [redacted] 02/22/2023)***

## 85a - Sanitary Conditions

**3. Requirements**

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

**Description of Violation**

*The bathroom in room [redacted] has no method of hand drying available.*

**Plan of Correction** ***Accept [redacted] - 02/08/2023)***

*A. With respect to the specific resident or event cited.*
*The bathroom in room [redacted] has no method of hand drying available.*

- *Room [redacted] at the time of inspection, was an unoccupied unit. The home has bath towels readily available in the linen supply closet. On 2/4/2023, two sets of towels, including wash clothes, were placed in the bathroom of room [redacted].*
- *Housekeeping staff educated on 2/8/2023. Please see attachment.*

*B. With respect to what systemic measures have been put in place to address the stated concern.*

- *Moving forward, at the time of the room turn, housekeeping will ensure that bath towels are readily available n the room. This task has been added to the housekeeping room turn checklist and will be monitored for compliance by the Housekeeping Supervisor.*

**Licensee's Proposed Overall Completion Date:** *02/06/2023*

***Implemented ([redacted] 02/22/2023)***

## 96a - First Aid Kit

**4. Requirements**

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

## 96a - First Aid Kit *(continued)*

**Description of Violation**

*The first aid kit in the 3rd floor medication room does not include disposable gloves.*

**Plan of Correction** ***Accept [redacted] - 02/08/2023)***

*A. With respect to the specific resident or event cited.*
*The first aid kit in the 3rd floor medication room does not include disposable gloves.*

*B. Identified concerns and corrective action.*

- *mmediately at the time of inspection, disposable gloves were added to the 3rd-floor medication room first aid kit to ensure the kit includes: disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings, and tweezers.*

*C. With respect to what systemic measures have been put in place to address the stated concern.*

- *A new audit tool was created for the Med Techs to check the first aid kit and immediately let DHW know if anything is needed. Please see attachment.*

*D. With respect to how the plan of corrective measures will be monitored.*

- *Med Techs will immediately begin utilizing the newly created audit tool. The Executive Director and/or designee will conduct weekly audits x4 weeks. Then random audits will continue to remain in compliance with 2600.96.a.*

**Licensee's Proposed Overall Completion Date:** *02/08/2023*

***Implemented [redacted] 02/22/2023)***

## 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 #1 does not have access to a source of light that can be turned on/off at bedside.*

**Plan of Correction** ***Accept [redacted] 02/08/2023)***

*A. With respect to the specific resident or event cited.*

- *Resident #1 does not have access to a source of light that can be turned on/off at bedside.*

*B. With respect to how the facility will identify residents with potential for the identified concern and take corrective action.*

- *Resident #1 had two working lamps in the apartment but not at the bedside. Wellness Director educated resident #1 on the importance of having a lamp at the bedside, and a lamp was placed at the bedside on 2/3/2023.*

*C. With respect to what systemic measures have been put in place to address the stated concern.*

- *A complete audit of all apartments was completed on 2/4/2023 to ensure each resident room had an operable amp or another source of lighting that the bedside could turn on.*

*D. With respect to how the plan of corrective measures will be monitored.*

- *Weekly audits of (10 residents) lamps are within reach of bedside x4 weeks. Results will be reported at the Quality Assurance Meeting. Residents will also be educated on the importance of having a lamp during the*

## *101j7 - Lighting/Operable Lamp (continued)*

*resident council meetings.*

**Licensee's Proposed Overall Completion Date:** *02/08/2023*

***Implemented [redacted] 02/22/2023)***

## 102i - Soap Dispenser

**6. Requirements**

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

**Description of Violation**

*There is no soap in the bathroom in room [redacted]*

**Plan of Correction** ***Accept [redacted] 02/14/2023)***

*A. With respect to the specific resident or event cited.*
*There is no soap in the bathroom in room [redacted]*

*B. With respect to how the facility will identify residents with potential for the identified concern and take corrective action.*

- *Room [redacted], at the time of inspection, was an unoccupied unit. The home has bathroom soap readily available from the housekeeping department. On 2/4/2023, hand soap was placed in the bathroom of room [redacted]*

*C. With respect to what systemic measures have been put in place to address the stated concern.*

- *Housekeeping Director and/or designee conducted an initial audit of the home's resident bathroom to ensure compliance with the regulation on 2/4/2023.*
- *Housekeeping staff educated on, 2/8/23, ensuring soap dispensers are provided within easy reach at each bathroom sink.*

*Please see attachment.*

*D. With respect to how the plan of corrective measures will be monitored.*

- *Housekeeping Director and/or designee to conduct weekly audit x2 months to ensure compliance beginning the week of 2/13/2023 . ED to conduct random room inspections to ensure compliance.*

**Licensee's Proposed Overall Completion Date:** *02/09/2023*

***Implemented [redacted] 02/22/2023)***

## 162c - Menus Posted

**7. Requirements**

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

## 162c - Menus Posted *(continued)*

**Description of Violation**

*The home did not have a weekly menu posted in a conspicuous and public place in the home.*

**Plan of Correction** ***Accept [redacted] 02/08/2023)***

*A.. With respect to the specific resident or event cited.*
*The home did not have a weekly menu posted in a conspicuous place in the home.*

*B. With respect to how the facility will identify residents with potential for the identified concern and take corrective action.*

- *The daily menu was posted, but the weekly menu had been temporari y moved during dining room remodeling. The violation was immediately corrected at the time of inspection with the current menu and one week in advance stating the specific food being served placed in the lobby.*

*C. With respect to what systemic measures have been put in place to address the stated concern.*
*The Culinary Director immediately ordered a new wall-mount display, which was hung in the lobby on 2/6/2023.*

*D. With respect to how the plan of corrective measures will be monitored.*

- *Rounds will be conducted by the dining manager and/or culinary director to ensure that the current menu and the one for the next week are posted in this new display. Weekly audits will be made x4 weeks to ensure the menus are in place. Biweekly audits will then be made x2 months to ensure the menus are in place. Results will be reviewed during the quality assurance meeting.*

**Licensee's Proposed Overall Completion Date:** *02/08/2023*

***Implemented [redacted] 02/22/2023)***

## 185a Implement Storage Procedures

**8. 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**

*The following errors were found when comparing resident #2's glucometer to the resident's medication administration record:*

- *On 1/31/23 at 4:35 pm, glucometer reads [redacted] the medication administration record reads [redacted]*
- *On 1/31/23 at 11:32 am, glucometer reads [redacted] the medication administration record reads [redacted]*
- *On 1/31/23 at 7:32 am, glucometer reads 168, the medication administration record reads [redacted]*
- *On 1/28/23 at 9:00 pm, the medication administration record reads [redacted] this reading is not on the glucometer*

**Plan of Correction** ***Accept [redacted] - 02/14/2023)***

## *185a - Implement Storage Procedures (continued)*

*A. With respect to what systemic measures have been put in place to address the stated concern.*

- *DHW immediately, at the time of inspection, ordered a new glucometer for resident #2 from the pharmacy, and it was calibrated to the correct date and time when delivered. No other residents were identified to be affected.*
- *DHW provided education to the nursing staff to demonstrate how to calibrate the glucometer and change the date and time when necessary on 2/7/2023. See attachment.*

*B. With respect to how the plan of corrective measures will be monitored.*

- *DHW and/or designee will review glucometer machine readings and MAR for consistent documentation weekly x4 weeks beginning the week of 2/6/23 , then monthly x3 months. Compliance will be ongoing and reviewed during quality assurance meetings.*

**Licensee's Proposed Overall Completion Date:** *02/09/2023*

***Implemented [redacted] 02/22/2023)***

## 227g -Support Plan Signatures

**9. 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 #2's support plan dated [redacted] /22 was not signed by the assessor.*

*Repeat Violation Date: 2/23/22.*

**Plan of Correction** ***Accept [redacted] - 02/14/2023)***

*A. With respect to the specific resident.*

- *Resident #2's support plan dated [redacted] /22 was not signed by the assessor.*

*B. With respect to how the facility will identify residents with potential for the identified concern and take corrective action.*

- [redacted]
  *The new DHW will continue to train the clinical staff for all required signatures for the support plan. Initial training completed on 2/7/2023. See attachment.*

*C.. With respect to how the plan of corrective measures will be monitored.*

- *The new DHW and/or designee will conduct an initial audit of all support plans and will continue to conduct a bi-annual audit of all RASPs to ensure all required signatures are reflected accurately to ensure compliance with the regulation. This audit is in process with completion expected by 2/17/23.*
- *DHW and/or designee to audit 10 resident RASP/Prescreen/DME, beginning on 2/9/2023 until all are reviewed.*
- *DHW and/or designee to develop a tickler system to ensure compliance moving forward.*

**Licensee's Proposed Overall Completion Date:** *02/09/2023*

***Implemented [redacted] /22/2023)***