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

April 4, 2023

[redacted]
ANNS CHOICE INC
16000 ANN'S CHOICE WAY
WARMINSTER, PA, 18974

RE: ANN'S CHOICE
16000 ANN'S CHOICE WAY
WARMINSTER, PA, 18974
LICENSE/COC#: 12901

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/08/2023, 02/09/2023 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: *ANN'S CHOICE* **License #**: *12901* **License Expiration**: *07/22/2023*

Address: *16000 ANN'S CHOICE WAY, WARMINSTER, PA 18974*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *ANNS CHOICE INC*

Address: *16000 ANN'S CHOICE WAY, WARMINSTER, PA, 18974*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/19/2018* **Issued By**: *Warminster Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *109* **Waking Staff**: *82*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *02/09/2023*

Inspection Dates and Department Representative

02/08/2023 - On-Site: [redacted]

02/09/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *63*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *44* **Residents Served**: *41*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

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

Have Mobility Need: *46* **Have Physical Disability**: *0*

Inspections / Reviews

02/08/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/10/2023*

03/15/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/31/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/01/2023*

Inspections / Reviews *(continued)*

04/04/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/31/2023*

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

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• Education of all Staff A was completed with Staff Development Coordinator.

• Education on Fire Safety and Emergency Procedures will be provided to all new PC staff by the Staff Development Coordinator or their designee prior to direct care staff first work day.

• Training records for all new employees hired effective 3/13/23 or later will be audited to ensure training was completed. Audits to be bi-weekly for 1 month, then monthly x 1 month to ensure all staff received staff training prior to their first day of work.

• Review of audit to be presented at monthly QAPI meeting.

In addition to above plan of correction: *All current staff records shall be audited to ensure all required training is completed. Audits to be kept for Department review.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (MJ - 04/04/2023)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.

65b - Rights/Abuse 40 Hours *(continued)*

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed his/her 40th scheduled work hour on [redacted]. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Staff person A completed his/her 40th scheduled work hour on [redacted]. However, this staff person did not complete training in the following topics: emergency medical plan.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• Education of all Staff A was completed with Staff Development Coordinator.
• Education on Resident Rights, the Emergency Medical Plan, Mandatory Reporting of Abuse and Neglect and the Reporting of Reportable Incidents and Conditions will be provided to all new staff by Staff Development Coordinator or their designee within the first 40 scheduled hours of work for direct care staff persons, ancillary staff persons, substitute personnel and volunteers
• Training records for all new employees hired effective 3/13/23 or later will be audited to ensure training was completed. Audits to be bi-weekly for 1 month, then monthly x 1 month to ensure all staff received staff training prior to their completion of their first 40 scheduled work hours.
• Review of audit to be presented at monthly QAPI meeting.

In addition to above plan of correction: *All current staff records shall be audited to ensure all required training is completed. Audits to be kept for Department review.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (MJ - 04/04/2023)

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 2/8/2023 and again on 2/9/2023, the secure closet that houses poisons in the memory care unit (SDCU) was unlocked and left open with multiple items that read to contact poison control.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• Doors were immediately latched
• All Memory Care Staff will be educated on the importance of ensuring all doors are tightly latched at all times, staff to shut doors if they observe them open and to ensure nothing occludes the door closure. Training to be completed by 3/31/23

82c - Locking Poisonous Materials (continued)

• Maintenance to verify that locks are latching appropriately and no further maintenance needed by 3/31/23.

Licensee's Proposed Overall Completion Date: 04/30/2023

Implemented (MJ - 04/04/2023)

101j7 - Lighting/Operable Lamp

4. 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 (MJ - 03/15/2023)***

• PC manager will complete audit of all rooms to identify any rooms that do not have bed side lighting. Families will be contacted by 3/10/23 to request that they please bring bedside lamps for residents by 3/24/23.
• The PC Manager will request that Finance purchase enough "puck" lights that may be adhered to walls be purchased for all families that decline to bring in bedside lamp and/or for those rooms that don't have lamps by 3/31/23. Small inventory to be maintained.
• On 3/31/23, a repeat will be completed to ensure all resident rooms have bedside lighting.
• Review of audit to be presented at monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: 04/30/2023

Implemented (MJ - 04/04/2023)

107d - Procedure Emergency Management Agency Submission

5. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency agency since 3/8/2021.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• The home's written emergency procedures were submitted to the local emergency agency. An acknowledgment of receipt was received on 2/9/2023.
• The home's written emergency procedures will be submitted to local emergency agency by the PC administrator annually.

Licensee's Proposed Overall Completion Date: 04/30/2023

Implemented (MJ - 04/04/2023)

121a - Unobstructed Egress

6. 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 2/8/2023, the door on the first floor leading to the patio in which is not an exit was labeled as an emergency exit only.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• The "emergency exit only" labeling of the first floor door was removed.

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

Implemented (MJ - 04/04/2023)

185a - Implement Storage Procedures

7. 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 2/9/2023, Lantus Pen belonging to Resident 1 was opened and did not have a label to indicate the date of opening.

On 2/4/2023, at 4:00 pm, Resident 1's reading on the glucometer was 215, however it was documented on the medication administration record as 218.

On 2/5/2023, at 4:00 pm, Resident 1's reading on the glucometer was 239, however it was documented on the medication administration record as 267.

On 2/8/2023, at 8:00 am, Resident 1's reading on the glucometer was 163, however it was documented on the medication administration record as 165.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• PC nurse to be educated on the reading and documentation of the glucometer and proper labeling of medications.
• A nurse will complete a random weekly audit of 100% of all PC residents with an order for an insulin pen to ensure pens are properly dated will be completed beginning 3/12/23 x 4 weeks, ending 4/15/2023.
• A nurse will complete a random weekly audit of 100% of all PC residents with an order for glucose monitoring beginning 3/12/23 x 4 weeks, ending 4/15/2023.
• Findings will be reviewed at QAPI meeting monthly until resolved.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (MJ - 04/04/2023)

187d - Follow Prescriber's Orders

8. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 2 is prescribed Pepcid 20 mg. However, this medication was not administered to resident 2 on 1/2/2023 because the medication was not available in the home.

Resident 2 is prescribed Aricept 5 mg. However, this medication was not administered to resident 2 on 2/4/2023 because the medication was not available in the home.

Resident 3 is prescribed Eliquis. However, this medication was not administered to resident 3 on 1/11/2023 because the medication was not available in the home.

Resident 4 is prescribed Acetaminophen 325 mg. However, this medication was not administered to resident 4 on 1/11/2023 because the medication was not available in the home.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• Education on proper ordering of medications will be provided to PC staff who are responsible for ordering medications by 3/31/23.
• A nurse or PC manager will audit 10% of PC resident's medications weekly to ensure medication is available. The audit will begin the week of 3/13/2023 and be repeated x4 weeks, ending 4/15/2023.
• Findings will be reviewed at monthly QAPI meeting.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (MJ - 04/04/2023)

224a - Preadmission Screen Form

9. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 5 was admitted to the home on [redacted]; however, the resident's preadmission screening form was not completed on the correct form.

Resident 6 was admitted to the home on [redacted]; however, the resident's preadmission screening form was not completed on the correct form.

Resident 7 was admitted to the home on [redacted] however, the resident's preadmission screening form was not completed on the correct form.

224a - Preadmission Screen Form (continued)

Resident 8 was admitted to the home on [redacted] however, the resident's preadmission screening form was not completed on the correct form.

Resident 9 was admitted to the home on [redacted] however, the resident's preadmission screening form was not completed on the correct form.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• The Department's preadmission screening form will be utilized within the 30 days prior to admission to determine that the needs of the resident can be met by the services provided by the home.
• Weekly Audits will be completed by PC Administrator or designee for 4 weeks starting 3/13/23 to ensure Preadmission screen was completed on the Department form.
• Findings will be reviewed at QAPI meeting.

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (MJ - 04/04/2023)

233c - Key-Locking Devices

10. 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

The directions for operating the home's locking mechanism are not conspicuously posted near the door to exit the Secure Dementia Care Unit (SDCU) from the Patio exit.

Plan of Correction ***Accept (MJ - 03/15/2023)***

• Directions for operating the home's locking mechanism were conspicuously posted near the door to the exit of the Secure Dementia Care Unit (SDCU) from the patio.

In addition to above plan of correction: *Administrator or designee shall check weekly to ensure directions are posted.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (MJ - 04/04/2023)