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

March 27, 2023

VS WALLINGFORD LLC
2700 CHESTNUT PARKWAY
CHESTER, PA, 19013

RE: CHESTNUT RIDGE RETIREMENT LIVING
2700 CHESTNUT PARKWAY
CHESTER, PA, 19086
LICENSE/COC#: 14141

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/09/2023, 02/22/2023, 02/24/2023 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CHESTNUT RIDGE RETIREMENT LIVING* **License #**: *14141* **License Expiration**: *12/30/2023*

Address: *2700 CHESTNUT PARKWAY, CHESTER, PA 19086*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *VS WALLINGFORD LLC*

Address: *2700 CHESTNUT PARKWAY, CHESTER, PA, 19013*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/19/1998* **Issued By**: *City of Chester*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *162* **Waking Staff**: *122*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *02/09/2023*

Inspection Dates and Department Representative

02/09/2023 - On-Site:
02/22/2023 - Off-Site:
02/24/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *130*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Car* **Capacity**: *22* **Residents Served**: *20*

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *82*
Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *32* **Have Physical Disability**: *4*

Inspections / Reviews

02/09/2023 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/13/2023*

Inspections / Reviews *(continued)*

03/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/24/2023*

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

03/27/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/24/2023*

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], the home documented that resident #1 was transported to the hospital, due to confusion, slurred speech, and a high glucose reading of 578. The resident was admitted to the hospital. The home did not report this incident to the Department.
On [redacted], resident #2 report an unwitnessed fall in their room. Resident #2 was unsure if there was head trauma. Resident #2, was sent to the hospital for further evaluation. The resident was admitted to the hospital. The home did not report this incident to the Department.

Repeat violation: 6/27/22

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

Reporting initially was not completed per PA §2600.16c (3) – "A serious bodily injury or trauma requiring treatment at a hospital or medical facility. This does not include minor injuries such as sprains or minor cuts."

Resident #1 has a known diagnosis of diabetes with a history of elevated glucose.

Resident #2 was transported to the hospital for evaluation after fall without noted injury. Hospitalization related to medical issue of urinary tract infection.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Executive Director re-educated Direct Care Staff responsible for 911 transfers at a clinical care meeting held on 2/24/23 that included:

- *The home will continue to follow Regulation 16c (3) guidelines and ensure all required incident reporting is completed within 24 hours.*
- *Direct care staff were provided state incident reporting guidelines per Regulation 16c (3), with acknowledgement and understanding that the Executive Director, Wellness Director, or designee must be notified of a resident incident that requires medical attention, intervention, or transport to the hospital to assist with determining if the incident falls within the state reportable guidelines.*
- *Incidents/Hospitalizations will be reviewed in morning stand up by the Executive Director, Wellness Director, or designee to ensure if a required reportable incident was completed and sent to state within the 24-hour reporting guideline.*

With Respect to How the Plan of Corrective Measures will be Monitored:

16c - Written Incident Report (continued)

Incident Reports will be reviewed and discussed during Monthly Quality Assurance Meetings by the Wellness Director.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented (MJ - 03/27/2023)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

Room # had a strong odor of urine.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

During the inspection, upon notification of the urine odor, the Housekeeping Supervisor attended to the room to clean and sanitize the bathroom for the resident who is independent with their bladder control.

The home will continue to support the resident in their independence of utilizing the bathroom on their own.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Direct Care Staff will be re-educated by 3/17/2023 by the Wellness Director on checking residents' bathrooms when they complete room/resident checks during their shift to ensure cleanliness and report any odors to Charge Nurse or Housekeeping team to have the odor addressed immediately.

With Respect to How the Plan of Corrective Measures will be Monitored:

Ongoing monthly audits will be conducted by the Housekeeping Supervisor to ensure residents' rooms are sanitarily maintained linens per Regulation 85a. Audits will be discussed and reviewed during the Monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented (MJ - 03/27/2023)

85a - Sanitary Conditions *(continued)*

101j3 - Bed/Linens/Pillows/Blankets

3. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed linen for resident in room [redacted] were stained and unclean. The pillow did not have a pillowcase.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

During the inspection, upon notification of the missing pillowcase and stained linen, the Housekeeping Supervisor attended to the room and removed sheets that appeared to have coffee stains on them possibly from resident spilling morning coffee. New linens, including pillowcase, were applied to the resident's bed.

With Respect to Systemic Measures that have been put into place to address the stated concern:

An audit was completed by the Wellness Director of all apartments on 2/13/23 and 2/14/23 and no further linen issues were identified. Direct Care Staff will be in-serviced by 3/17/2023 to observe for unclean linen and change linens as necessary.

With Respect to How the Plan of Corrective Measures will be Monitored:

Ongoing monthly audits will be conducted by the Housekeeping Supervisor to ensure residents are provided with bed linens per Regulation 101.j. Audits will be discussed and reviewed during the Monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented (MJ - 03/27/2023)

101o - Walls, Floors, Ceilings

4. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The carpet in the bedroom of room #[redacted] was not vacuumed and unclean.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

101o - Walls, Floors, Ceilings (continued)

With Respect to the specific deficiency cited:

During the inspection, upon notification of room [redacted] needing to be vacuumed, the Housekeeping Supervisor attended to the vacuuming and cleaning that was needed because of the resident eating breakfast in their apartment that morning.

With Respect to Systemic Measures that have been put into place to address the stated concern:

An audit was completed by the Wellness Director of all apartments on 2/13/23 and 2/14/23 and no further vacuuming or cleaning issues were identified.

Housekeeping Supervisor or weekend lead/designee will complete random daily room checks and have housekeeping address if need is immediate or have concern logged into the community Preventative Maintenance communication system, [redacted], for a work order to be generated and concern addressed per need. Direct Care Staff will be in-serviced by 3/17/2023 to notify housekeeping of any immediate cleaning needs.

With Respect to How the Plan of Corrective Measures will be Monitored:

Ongoing monthly audits will be conducted by the Housekeeping Supervisor to ensure residents are rooms are vacuumed and clean per Regulation 101.o. Audits will be discussed and reviewed during the Monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented (MJ - 03/27/2023)

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 2/9//23, at 11:12 am, the Glucometer belonging to resident #1, displayed the time as 12:12pm.

On 2/9/23, at 3:49 pm, the Glucometer belonging to resident #3, was not calibrated to the correct date and time. The Glucometer displayed the time as 8:17 am and the date as 2/4/23.

Plan of Correction ***Accept (MJ - 03/21/2023)***

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

185a - Implement Storage Procedures (continued)

With Respect to the specific deficiency cited:

Wellness Director designee audited all glucometers for accurate date and time of blood glucose collection.

Audit completed: 2/10/2023

With Respect to Systemic Measures that have been put into place to address the stated concern:

Bi-annually, glucometers will be checked for Daylight Savings and reset if required.

Audits will begin 3/13/2023

With Respect to How the Plan of Corrective Measures will be Monitored:

Glucometer audits will be reviewed and discussed during Monthly Quality Assurance Meetings by the Wellness Director or designee.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented (MJ - 03/27/2023)

187a - Medication Record

6. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #4 is prescribed Acetaminophen 325 mg. This medication was on the medication cart; however, it is not included on resident #4’s medication administration record.
Resident #4 is prescribed Atropine 1% oral drops. This medication was on the medication cart; however it is not on resident #4's medication administration record.

187a - Medication Record (continued)

Plan of Correction ***Accept (MJ - 03/21/2023)***

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

During the inspection, upon notification of the medication errors, Resident #4 physician's orders were reviewed. Per medical order, Acetaminophen 325mg was discontinued as it did not appear on the medication record for administration. Medication was immediately removed from the cart. Resident #4 is not and was not prescribed Atropine 1% oral drops and this violation was not reviewed with the home.

With Respect to Systemic Measures that have been put into place to address the stated concern:

An audit of all medication carts was completed on 2/20/23 and 2/21/23 by the Wellness Director designee (Exhibit III) and all medications were present in the home per physician order.

With Respect to How the Plan of Corrective Measures will be Monitored:

Ongoing monthly medication cart audits will be conducted during the medication cart cycle fill process by the Wellness Director, or designee, to ensure residents' medications are present in the home per physician order per Regulation 187.a. Audits will be discussed and reviewed during the Monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented (MJ - 03/27/2023)

201 - Positive Interventions

7. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident #5, has hoarding tendencies per staff interviews. His/Her bedroom is cluttered with things that are a tripping hazard. The home has not implemented positive interventions to modify or eliminate the behavior.

Plan of Correction ***Accept (MJ - 03/21/2023)***

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

201 - Positive Interventions (continued)

Resident #2 has hoarding tendencies (not Resident #5), however both residents reside together. At the time of the inspection, Resident #2 was on a leave of absence from the home. Prior to the 2/9/2023, the Executive Director had contacted Resident #2 POA to devise a plan to declutter the bedroom and begin to seek positive interventions for the Resident's hoarding tendencies.

With Respect to Systemic Measures that have been put into place to address the stated concern:

On 2/11/2023, the Executive Director met with the POA and a storage unit in the home was rented to begin moving some of the clutter out of the bedroom. The POA contracted a third party downsizing company to assist in selecting items of no value . That company was present in the home on 2/13/23 and the bedroom was decluttered.

An audit was conducted by the Wellness Director on 2/13/2023 and 2/14/2023 of all resident rooms to ensure fire and safety measures are in place. No further issues were identified.

Resident #2 returned to the home on, and a care conference was held with them and their POA. Medication management was given to the home and the resident was agreeable to allowing Direct Care Staff and Housekeeping staff assist in their bedroom upkeep. Care plan was updated to reflect these care needs.

With Respect to How the Plan of Corrective Measures will be Monitored:

Ongoing monthly audits will be conducted by the Housekeeping Supervisor to ensure safe management techniques are applied to hoarding tendencies per Regulation 201. Audits will be discussed and reviewed during the Monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *03/17/2023*

Implemented (MJ - 03/27/2023)

227g -Support Plan Signatures

8. 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, participated in the development of support plan on . However, the resident did not sign the support plan. The signature page was missing from assessment.

Plan of Correction ***Accept (MJ - 03/21/2023)***

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

During the inspection, upon notification of missing signature page from Resident #2 support plan, the Wellness Director confirmed that the signature page was missing. Resident #2 was on a leave of absence from the home until

227g -Support Plan Signatures (continued)

With Respect to Systemic Measures that have been put into place to address the stated concern:

Resident #2 returned to the home on [redacted] with a status change DME. The Resident Assessment and Support Plan for resident #2 was completed and reviewed with resident and POA on [redacted]

An audit was completed on all DME and Support Plans on 2/15/2023, and no other residents were affected.

With Respect to How the Plan of Corrective Measures will be Monitored:

Wellness Director, or designee will audit service plans accordingly. DME and Support Plans will be reviewed by the Wellness Director, or designee monthly.

Licensee's Proposed Overall Completion Date: *03/12/2023*

Implemented (MJ - 03/27/2023)