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

June 6, 2023

DEVEREUX FOUNDATION INC

RE: DEVEREUX PA ADULT SERVICES PCH
- HILLCREST COTTAGE
229 LEOPARD ROAD
BERWYN, PA, 19312
LICENSE/COC#: 19814

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/03/2023 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: *DEVEREUX PA ADULT SERVICES PCH HILLCREST COTTAGE* **Licen e #**: *19814* **Licen e Expiration**: *08/03/2023*

Address: *229 LEOPARD ROAD, BERWYN, PA 19312*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *DEVEREUX FOUNDATION INC*

Address:

Phone **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/13/2001* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *04/03/2023*

Inspection Dates and Department Representative

04/03/2023 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *21* **Re ident Served**: *13*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Re ident Served**:

Hospice

Current Re ident : *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older**: *9*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *8*

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

04/03/2023 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/23/2023*

Inspections / Reviews *(continued)*

04/25/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/01/2023*

05/01/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/30/2023*

06/06/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2023*

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 22, did not receive orientation on the following topics until /22: 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, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Accept (- 04/25/2023)***

Staff person A's hire date and general new staff orientation was 22. After a week-long orientation, Staff A's first day of work in the program was 22 and a unit (site/program) orientation was conducted by the administrator at which time the competency test was completed. Devereux requires more extensive training before staff can work in a program. Staff A completed the required PCH training before performing job duties on-site at the home.
The Program Supervisor will track the PCH training requirements for all new hires to ensure continued compliance effective 4/24/23 for three months up to 6/30/23.

Licensee's Proposed Overall Completion Date: *04/21/2023*

Implemented (- 06/06/2023)

89a - Water Pressure

2. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 04/03/23 at 3:30pm, the home did not have sufficient hot water in the home for showering. Resident's room were inspected for hot water temperature and read 90 degrees after three minutes wait.

Plan of Correction ***Accept (MS - 04/25/2023)***

A maintenance request was entered upon the discovery and the hot water temperature was restored to required temperature on 4/4/2023. Moving forward, Supervisor or staff person will check the water temperature weekly and put in maintenance request when the temperature is below the required temperature for three months effective 4/24/23 for three months up to 6/30/23.

89a - Water Pressure *(continued)*

Licensee's Proposed Overall Completion Date: *04/21/2023*

Implemented (MS - 06/06/2023)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

3. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

On 4/3/23, the shower in resident 1's bathroom does not have a slip-resistant surface.

Plan of Correction ***Accept (- 04/25/2023)***

After the discovery of missing bathmat in resident # 1 bathroom, a bathmat was purchased and placed in the bathtub on 4/3/2023. Moving forward, Supervisor will conduct a weekly check of individuals rooms/bathrooms for missing, damage items and either replaced them or put in maintenance request for repair for the next six months beginning 4/24/23 up to 6/30/23.

Licensee's Proposed Overall Completion Date: *04/21/2023*

Implemented (- 06/06/2023)

105g - Lint Removal and Duct Cleaning

4. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 04/03/22, there was an approximate two inch accumulation of lint in the lint trap of the home's dryer. There were no clothes in the dryer at the time.

Plan of Correction ***Accept (- 05/01/2023)***

The lint was cleared from the dryer's lint-trap after the discovery. Moving forward, the lint-trap will be cleaned from the dryer after each use. Supervisor will create a sign in log and hang it in laundry room for staffs' signatures. The supervisor will conduct a weekly check of the lint-trap beginning 4/24/23 for three months up to 6/30/23. There will be checks conducted at the end of each shift by the outgoing and the incoming staff to ensure that the lint trap is clean of any lint and document the check in the communication log. There will be an in-service training conducted during the monthly staff meeting about risk of not clearing of the lint traps.

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented (- 06/06/2023)

141b1 - Annual Medical Evaluation

5. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident 2's most recent medical evaluation was completed on [redacted]/22. The resident's previous medical evaluation was completed on [redacted]21.

Plan of Correction ***Accept ([redacted] - 05/01/2023)***

The lateness of the medical evaluation could not be immediately corrected. Moving forward, a weekly audit of medical evaluation dates will be conducted by the program nurse and nurse manager beginning 4/24/23 for three months up to 6/30/23. The nursing staff will be trained by 5/10/23 regarding their expectation in ensuring that medical evaluations are given to the PCP for completion along with the annual physical forms which are facility specific. It is the expectation of the PCP to complete the documentation completely, thoroughly, and accurately. If this isn't done, the nurse immediately contacts the doctor and resubmits the correction to them. This should be corrected within 7 business days from the time the error is identified. The nurse manager is responsible for following up with the nurse and the doctor on completion. Weekly audits to review the completion dates of the DME and the Devereux Annual Physical Form are to be submitted to the Director of Nursing weekly by the nurse and the nurse manager. This is currently ongoing and can extend through to 06/01/24. Failure to complete the audits will result in progressive disciplinary feedback.

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented ([redacted] - 06/06/2023)

183f - Discontinued Medications

6. Requirements

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 4/3/23 during the medication audit, The medication card of [redacted] belonging to resident 3 was present on the medication cart. The foil packaging securing the medication in the card was broken over one of the pills, requiring that the medication be destroyed for unsanitary storage of the medication. Staff member B destroyed the medication on site and disposed the [redacted] pill directly into the trash can. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation or the home's policy on destroying medication.

Plan of Correction ***Accept ([redacted] - 04/25/2023)***

The immediate correction was to identify the correct staff as it was not staff member B. The Director of Nursing will retrain the staff on the proper way to dispose of discontinued medication by 4/25/23. Moving forward the Supervisor will conduct a weekly check for discontinued medications and properly dispose of any medications along with the program nurse starting 4/24/23 and ending 6/30/23.

Licensee's Proposed Overall Completion Date: *04/21/2023*

Implemented ([redacted] - 06/06/2023)

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

Resident #2 is prescribed - take one tablet by mouth every two hours as needed .
On 04/03/23 this medication was not available in the home.

Plan of Correction ***Accept (- 05/01/2023)***

The medication for Resident #2 was reordered. Moving forward, the Supervisor will conduct a weekly audit to ensure all prescribed medication are present and will reorder as needed. The audit will start effective 4/24/23 for three months up to 6/30/23. In addition to overnight medications checks, the supervisor will review the overnight checks every morning and have staff compare the checks to medications on the morning shift to check the accuracy of the check done by the overnight. If discover any incorrect check, the supervisor will have 1:1 meeting with the staff responsible for a retraining and other appropriate actions to address the inaccuracy

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented (- 06/06/2023)

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

On /23, resident#3 was administered for and the count was reduced to one left. The sheet from /23 through 23 was verifying the count as two left and it was signed off as verified. On 23 the home adjusted the count to one. This discrepancy should have been identified by the staff responsible for counting at each shift change.

Plan of Correction ***Accept (- 05/01/2023)***

The medication count error was corrected with a new order. Moving forward, outgoing staff responsible for the narcotic count will double count with incoming staff to verify that the count is correct before entering on sheet. Supervisor will review that count sheet weekly for any missed count and take appropriate action to address it and will start effective 4/24/23 for three months up to 6/30/23. The supervisor will review the control count sheet along with the actual medications to ensure that the counts are accurate once every day and document in the communication log of discovery any error. There will be in-service training for staff responsible and appropriate actions will be taken to address error.

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented (- 06/06/2023)

191 - Resident Right to Refuse

9. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

191 - Resident Right to Refuse *(continued)*

Description of Violation

Resident #3,who was admitted to the home on /21, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 05/01/2023)***

Resident #3 was admitted to Devereux on 21 but to a home under different regulations. Resident #3 was transferred/admitted to Hillcrest on /21 and educated on right to refused medication on 21. Moving forward, supervisor will conduct a weekly audit of any new admissions to ensure continued compliance with providing education on the resident's right to refuse medication effective 4/24/23 for three months up to 6/30/23. Resident Rights will be included in the admission package and new admissions will be educated by the administrator on their right to refuse medication on the day of admission. The resident will sign the rights and will be filed in the resident's PCH binder. The Supervisor will review the binders immediately after the admission process to ensure that is included and properly filed. Also, the supervisor will conduct a check once a month to ensure that all required documents are in the binders and up-to-date.

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented (- 06/06/2023)

224a - Preadmission Screen Form

10. 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 #1 was admitted to the home on /23; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept (- 05/01/2023)***

The lateness of the screening could not be immediately corrected. Moving forward, the pre-admission screening/determination will be completed within 30 days prior to admission by a PCH administrator and tracked effective 4/24/23 for three months up to 6/30/23. There will be a review of new admission PCH binders immediately after the admission process is complete to ensure that all required documentations are properly filed in the binder and continue the review for at least three months from 4/30/2023 to 8/1/2023.

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented (- 06/06/2023)