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

June 5, 2023

[redacted]
VS WOODS LLC
[redacted]

RE: THE WOODS AT CEDAR RUN
824 LISBURN ROAD
CAMP HILL, PA, 17011
LICENSE/COC#: 33132

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/04/2023, 04/05/2023 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: *THE WOODS AT CEDAR RUN* **Licen e #**: *33132* **Licen e Expiration**: *12/31/2023*

Address: *824 LISBURN ROAD, CAMP HILL, PA 17011*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *VS WOODS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *02/19/1997* **I ued By**: *Department of Labor and Industry*

Type: *Other* **Date**: *07/18/2014* **I ued By**: *Lower Allen Township*

Staffing Hours

Resident Support Staff: *o* **Total Daily Staff**: *NaN* **Waking Staff**: *NaN*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/05/2023*

Inspection Dates and Department Representative

04/04/2023 On Site [redacted]

04/05/2023 On Site [redacted]

[redacted] Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *58*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *19* **Residents Served**: *14*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *17* **Have Physical Disability**: *0*

Inspections / Reviews

04/04/2023 - Full

Lead Inspector [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/21/2023*

Inspections / Reviews *(continued)*

04/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/02/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/28/2023*

04/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/02/2023*

Reviewer [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/02/2023*

06/05/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/02/2023*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 4/4/2023 at 9:23 AM, the "2nd floor Resident Care" binder containing resident narcotic counts was unlocked, unattended, and accessible on the 2nd floor Medication Cart.

On 4/4/2023 at 9:45 AM, the "MC Resident Care" binder containing resident narcotic counts was unlocked, unattended, and accessible on the Memory Care Medication Cart.

On 4/5/2023, the Second Floor Medication Cart West, located in the second floor dining room, was observed to have Resident #1's information open on a computer screen; the medication cart and computer were unattended.

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

On 4/4/23 Executive Operations Officer (EOO) removed the binder from the 2nd floor cart and Memory care cart at time of finding and provided it to the Med Tech.

On 4/5/23 at time of finding EOO placed computer in lock mode concealing PHI.

Daily audits were conducted from 4/5- 4/17 by the Resident Wellness Director (RWD) and/or EOO to ensure confidentiality of resident information is maintained. Ensuring computers are in lock mode when unattended, and narcotic binders are secured in the medication carts. No findings during the audit.

Med Techs will be formally educated by the RWD by 5/31/23 on regulation 2600.17

To monitor ongoing compliance, random weekly audits will continue by the EOO and/or RWD starting 4/17/23. Audits will be reviewed during QI meetings.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented ([redacted] - 06/05/2023)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 3/27/2023, from 11:00 PM to 7:00 AM, 58 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

63a - First Aid/CPR Training (continued)

On 3/31/2023, from 11:00 PM to 3:00 AM, 58 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Repeated Violation - 3/29/2022, et al

Plan of Correction ***Accept (04/28/2023)***

Executive Operations Officer identified this violation and completed and audit in March 2023. First aid/CPR training was scheduled at trainer's availability of 5/4/23 with RCA and Med Techs whose training expired are scheduled to be n attendance.

Resident Wellness Director (RWD) in conjunction with the unit clerk/scheduler will maintain the tracking log initiated n March 2023 to ensure compliance with regulation 2600.63a. The Unit Clerk will add new hires to the tracking log.

RWD in conjunction with the unit clerk/scheduler will schedule CPR trainings prior to expiration of cert., coordinating with the facility CPR trainer. A monthly audit, beginning 5/8/23, will be completed by the unit clerk/schedu er and provided findings to the RWD.

RWD/EOO will provide education on regulation 2600.63a to the unit clerk/scheduler by 5/5/23

After completion of CPR, the Unit Clerk/scheduler will be responsible to review the schedule for appropriate number of certifications beginning 5/4/23

Audits will be reviewed during QI meetings.

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

Implemented (- 06/05/2023)

65d - Initial Direct Care Training

3. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct Care Staff Member A, hired on /2022, provides unsupervised ADL services. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test as of /2023.

65d - Initial Direct Care Training *(continued)*

Plan of Correction ***Accept (- 04/28/2023)***

On 4/5/23 Direct Care Staff Member A was removed from the schedule and assigned to complete the Dept.- approved direct care training course/test.

On 4/7/23 Direct Care Staff Member A completed and passed the Dept.- approved direct care training course/test.

Administrative Service Direction (HR rep.) was verbally educated by Executive Operations Officer (EOO) on 4/5/23 regarding regulation 2600.65d

Administrative Service Direction (HR rep.) and EOO will complete an audit of all Direct Care Staff files to ensure compliance with regulation 2600.65d. A full audit of all personnel files will be completed by 4/28/23. Any Direct Care Staff Member found out of compliance with regulation 2600.65d will not provide unsupervised care assigned to complete Dept.- approved direct care training course/test.

To ensure ongoing compliance, ASD and/or EOO will audit each DCS employee's file prior to the employee providing unsupervised ADLs beginning 4/24/23.

Audit findings will be reviewed in QI Committee.

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

Implemented (- 06/02/2023)

65g - Annual Training Content

4. 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:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff Member B did not receive training in fire safety, completed by a fire safety expert or by a staff person trained by a fire safety expert; or emergency preparedness procedures and recognition and response to crises and emergency situations, during training year 2022.

Staff Member C did not receive training in fire safety, completed by a fire safety expert or by a staff person trained by a fire safety expert; or emergency preparedness procedures and recognition and response to crises and emergency situations, during training year 2022.

Plan of Correction ***Accept (- 04/28/2023)***

On 4/5/23 Executive Operations Officer (EOO) determined annual fire safety training related to regulation 2600.65g was not completed in the 2022 training year. There is no record of the training- no audit needed; all staff will need training.

EOO reviewed 2023 training plan on 4/6/23. The 2023 training plan does include fire safety training to be

65g - Annual Training Content (continued)

completed by end of second quarter. Safety and Maintenance Engineer (SME) is the homes identified fire safety trainer. SME will conduct fire safety training to all staff by 5/31/23.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented (- 06/02/2023)

81b - Resident Personal Equipment

5. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1 has an enabler bar on his/her bed with an opening greater than 4 ¾, which exceeds the FDA guidelines. On 4/5/2023, the enabler bar was observed to be uncovered and unsecured on resident's bed, posing a potential entrapment and/or fall hazard.

Plan of Correction ***Accept (- 04/28/2023)***

On 4/18/23 Executive Operations Officer (EOO) spoke with resident #1 re: identified hazard. Resident was reluctantly agreeable to cover the enabler and secure it to the bed. Accepted cover provided by the home, EOO applied the cover on 4/18, at this time the enabler was secure.

Resident Wellness Director (RWD) and EOO to completed full home audit of all residents with identified enablers to ensure DME meet the safety requirements in regulation 2600.81b by 5/5/23. Concerns will be addressed/resolved as dentified. Therapy will be consulted as needed.

RWD and EOO will complete education with admissions team, management team and wellness team on regulation 2600.81b by 5/31/23

Beginning 5/5/23, RWD/Medication Associates to complete monthly safety check to ensure resident rails/enablers are properly secured and covered. RWD/Medication Associate will complete immediate reconciliation should a hazard be identified.

Audits will be reviewed at QI committee meeting.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented (- 06/05/2023)

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

6. 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

There is no grab bar, hand rail or assist bar located near the bathroom toilet in Resident Room

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface *(continued)*

Plan of Correction ***Accept (CR - 04/28/2023)***

On 4/14/23 Safety and Maintenance Safety Engineer (SME) assessed resident room [redacted] and installed grab bars within reach on both the right and left side of the toilet.

SME and Executive Operations Officer (EOO) will complete an audit of all resident rooms to ensure grab bars are in place and functionally appropriate. Audit will be completed by 5/31/23. Any findings of the audit will be corrected within 1-10 business days pending equipment needed.

EOO will complete education with SME and wellness department regarding the regulatory requirement of 2600.102d by 5/31/23.

Findings of the audits will be reported in the homes Safety and QI committee.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented ([redacted] - 06/05/2023)

107d - Procedure Emergency Management Agency Submission

7. Requirements

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

Description of Violation

As of 4/5/2023, the home's written emergency procedures have not been reviewed since [redacted] 2022. The home does not have documentation that the emergency procedures have been submitted to the local emergency management agency.

Plan of Correction ***Accept ([redacted] - 04/21/2023)***

Executive Operations Officer (EOO) and Safety and Maintenance Engineer (SME) will review the written emergency procedures by 5/10/23, corrections, if needed, will be made by 5/31/23 by the SME and EOO.

The plan will be submitted to Lower Allen Township by 6/2/23 by the EOO.

EOO implemented agenda items to QI committee to ensure the plan is reviewed quarterly, and up to date for submission annually.

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

Implemented ([redacted] - 06/05/2023)

124 - Notice to Fire Department

8. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

124 - Notice to Fire Department *(continued)*

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept (- 04/28/2023)***

Executive Operations Officer (EOO) reviewed resident mobility needs and completed the written notice on 4/10/23.

EOO attached the current annual fire inspector letter to the written notice and hand delivered it to the Lower Allen Fire Dept. on 4/10/23 noted on the top of the letter.

EOO will implement agenda item in QI committee to review mobility needs monthly. EOO will update list accordingly and submit to the Lower Allen Fire Dept as changes occur.

Licensee's Proposed Overall Completion Date: *04/27/2023*

Implemented (- 06/02/2023)

141a 1-10 Medical Evaluation Information

9. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #3's annual medical evaluation did not include the date that the resident was evaluated or the date that the form was completed; the physician signed the form on /2022.

Plan of Correction ***Accept (- 04/28/2023)***

Resident 3 switched Physicians, the home is no longer able to verify date evaluated. Resident 3 will be scheduled for a new annual eval at the next available appointment, but no later than 6/28/23

Resident Wellness Director (RWD) will complete a whole home audit of all medical eval forms by 5/31/23 to ensure all forms are completed in its entirety. Should areas of noncompliance be identified these will be address within a

141a 1-10 Medical Evaluation Information (continued)

reasonable timeframe of 30 days.

Beginning 5/1/23, RWD will complete audit of medical evals as initial, annual, or status changes occurs to ensure the form is completed within its entirety. Immediate correction with coordinate of the physician will be made should any areas of the form not be completed.

RDW will complete education with the wellness department on regulation 2600.141a by 5/31/23.

Audit findings will be reviewed at the QI committee as audits are completed.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented ([redacted] - 06/05/2023)

185a Implement Storage Procedures

10. 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 4/5/2023 at approximately 10:20 AM, Resident #1's glucometer was not calibrated to the correct date or time.

Plan of Correction ***Accept ([redacted] 04/28/2023)***

Resident Wellness Director (RWD) spoke with Resident 1, who was unaware of the issue with the Glucometer brought from home. Resident 1 discharged on 4/10/23.

RWD will complete a whole home audit of current resident Glucometers by 4/30/23 to ensure proper functionality. If replacements need to be purchased, RWD will coordinate with resident/family. Audit completed with no findings.

Per the homes policy the Medication Associate will complete monthly audits using attached form, and the RWD will review for compliance. Audits have been in place using this form. Audit was not in place for the respite.

RWD will complete education with medication techs/LPNs regarding Glucometers, including glucometers for respites, related to regulation 2600.185a by 5/5/23.

RWD will report audit findings the QI committee.

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

Implemented ([redacted] - 06/05/2023)

227g -Support Plan Signatures

12. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

Resident #3 participated in the development of his/her support plan on [redacted]/2023. However, the resident and the assessor did not sign the support plan. There is no notation that the resident was unable to sign or participate or that the resident refused to sign.

Resident #4 participated in the development of his/her support plan on [redacted]/2022. However, the resident and the assessor did not sign the support plan. There is no notation that the resident was unable to sign or participate or that the resident refused to sign.

Repeated Violation - 3/29/2022, et al

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

Resident 3's signed support plan was reviewed and signed by the resident on 4/6/23. The assessor is the staff member reviewing the RASP with the resident.

Resident 4's support plan was reviewed and signed on 4/3/23 by the resident. The assessor is the staff member reviewing the RASP with the resident.

Resident Wellness Director (RWD) will complete a whole home audit of all resident support plans by 5/31/23 to ensure support plan signatures are present. Any missing signatures will be addressed at time of finding, and resident will review and sign within 1-3 business days. To monitor ongoing compliance after completion of audit, once full home audit is completed, RWD and/or EOO will complete ongoing monthly audits to ensure compliance with regulation 2600.227g.

RWD will complete education with the wellness team regarding regulation 2600.227g by 5/31/23

Audit findings will be reviewed in QI committee.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented ([redacted] - 06/05/2023)