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

June 28, 2023

[redacted]
1425 HORSHAM SNF OPERATIONS LLC
1425 HORSHAM ROAD
[redacted]
NORTH WALES, PA, 19454

RE: THE INN AT HORSHAM CENTER
FOR JEWISH LIFE
1425 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14706

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/09/2023 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: *THE INN AT HORSHAM CENTER FOR JEWISH LIFE* **Licen e #**: *14706* **Licen e Expiration**: *10/26/2023*

Address: *1425 HORSHAM ROAD, NORTH WALES, PA 19454*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *1425 HORSHAM SNF OPERATIONS LLC*

Address: *1425 HORSHAM ROAD,* [redacted] *, NORTH WALES, PA, 19454*

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *10/22/2001* **I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *27* **Waking Staff**: *20*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/09/2023*

Inspection Dates and Department Representative

05/09/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served**: *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *22*

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

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

05/09/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/29/2023*

05/23/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/23/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/29/2023*

Inspections / Reviews *(continued)*

05/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/25/2023*

06/28/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

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

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident room [redacted] has a bed equipped with enablers on both sides, which are about 10 inches high and 24 inches wide. On 5/9/23, these enablers were not covered to prevent entrapment.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

Resident Room [redacted] Volunteered to remove enabler on left side. Right side enabler covered with bed rail cushion pad. Left enabler was removed on 5/15/23. Right enabler covered on 05/15/23 by administrator. Administrator and DON will be responsible for quarterly audits to prevent recurrence.
Please see attached exhibit A
Please see attached exhibit E

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented ([redacted] - 06/28/2023)

105g - Lint Removal and Duct Cleaning

2. 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 05/09/2023, there was an approximate 1/2 inch accumulation of lint in the lint trap of one of the 3 dryers in the 2nd floor resident laundry room. There were no clothes in the dryer at the time.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

Lint was immediately removed from lint trap. Orders were placed in Point Click Care. Orders were placed in Point Click Care for staff to check and empty lint from dryer each shift (after every use) Staff must sign this out every shift/use daily. Starting 5/24/23 Nursing supervisors will check for staff signatures in PCC to ensure staff are completing/signing out for lint removal. Additionally nursing supervisors will check lint traps weekly. There are signs posted in the laundry rooms to remove lint from traps after each use.

Please see attached exhibit B
Please see attached Plan of Correction Lint

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented ([redacted] - 06/28/2023)

107a - Emergency Preparedness

3. Requirements

2600.

107a - Emergency Preparedness *(continued)*

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person A, the administrator, does not have a copy of the emergency preparedness plan for the local municipality.

Plan of Correction ***Accept (- 05/30/2023)***

Administration will keep a copy of updated EPP for local Municipality. EPP will be updated by 6/22/23. Audit of Emergency Preparedness Plan will be completed monthly x3 then annually thereafter. Beginning 06/22/2023- Director of Plant Operations, Administrator and will be responsible for audits to ensure compliance. Fire Safety Solutions will be completing annual reviews along with Director of Plant operations and Administrator.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented (- 06/28/2023)

107d - Procedure Emergency Management Agency Submission

4. 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 management agency since /2019.

Plan of Correction ***Accept (- 05/30/2023)***

Director of Plant Operations will be in-serviced by Fire and Safety Solutions ensuring a copy of plan is on file moving forward by 6/22/23 A copy of homes EPP will be submitted to local emergency management agency by 6/22/23 Director of Plant Operations will be in-serviced by Fire and Safety Solutions to ensure local emergency agency will receive updated copy annually. Plant op and PC administration will schedule yearly reviews to ensure updates.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented (- 06/28/2023)

121a - Unobstructed Egress

5. 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 05/09/2023 at 09:40 AM, the doors to the home's 3 stairwells (stairwell 15, 16 and 17) leading to the exits were locked and needed a badge to open them. Only staff members have a badge. The residents are not able to access these exits independently.

Plan of Correction ***Accept (- 05/30/2023)***

Stairwell was locked because there was an elopement of a former resident from the skilled Nursing Facility. Director of Plant Operations will conduct an in-service to let staff know all doors are required to be unlocked at all times by 06/22/2023. Stairwell 15, 16, and 17 leading to exits were unlocked 05/22/2023 Residents and staff are ab e to access these exits. Maintenance team began audit stairwell doors weeklyx4 to ensure they remain unlocked and

121a - Unobstructed Egress (continued)

monthly thereafter.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented ([redacted] - 06/28/2023)

132b Safety Inspection/Fire Drill

6. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety e pert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not have a fire safety inspection and fire drill conducted by a fire safety expert in 2021.

Plan of Correction ***Accept ([redacted] 05/30/2023)***

Center will contract a plan with Fire and Life Safety Solutions to manage our fire safety program including fire drills 6/22/23 Plant Ops will be responsible for communicating with Fire and Safety Solutions. The fire drill inspections will be kept on file for review. The Director of Plant Operations will be in-serviced by fire safety on an annual basis beginning 6/22/23. Audits will be conducted monthlyx3 that documentation is properly stored for review by Director Of Plant Operations by 6/22/23.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented ([redacted] - 06/28/2023)

132c - Fire Drill Records

7. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's monthly fire drill records do not include the number of residents in the home at the time of the drill.
The fire drill records for the drill conducted on 06/08/2022, 07/28/2022, and 04/21/2023 do not include the amount of time it took for evacuation.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

Fire drills will be completed by a certified fire expert by 6/22/23 and every month after to ensure evacuation times are in regulatory compliance. Director of Plant Operations will be in-serviced on evacuation requirements by a certified fire expert and Director Of plant Operations and Plant Ops supervisor will be licensed to become a fire safety expert by 06/22/2023. An Audit will be conducted monthly to ensure evacuation requirements are met by 06/22/2023.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented ([redacted] - 06/28/2023)

132d Evacuation

8. Requirements

132d - Evacuation *(continued)*

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

- *1/31/22: 2 minutes 51 seconds*
- *2/24/22: 2 minutes 52 seconds*
- *3/28/22: 3 minutes 37 seconds*
- *4/8/22: 3 minutes 45 seconds*
- *5/19/22: 3 minutes 15 seconds*
- *6/8/22: No evacuation time noted*
- *7/28/22: No evacuation time noted*
- *8/13/22: 3 minutes 9 seconds*
- *9/27/22: 2 minutes 59 seconds*
- *10/31/22: 2 minutes 51 seconds*
- *11/16/23: 2 minutes 56 seconds*
- *12/21/22: 3 minutes 33 seconds*
- *1/22/23: 3 minutes 48 seconds*
- *3/31/23: 3 minutes 57 seconds*
- *4/21/23: No evacuation time noted*

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

ire drills will be completed by a certified fire expert (Fire and Life Safety Solutions) to ensure evacuation times are in regulatory compliance by 6/22/23 and every month going forward. Director of Plant Operations will be in serviced on evacuation requirements by Fire and Life Safety Solutions by 06/22/2023 An audit will be conducted monthly x3 by director of plant operations to ensure evacuation requirements are met by 6/22/23.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented ([redacted] - 06/28/2023)

132h - Designated Meeting Place

9. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the home's monthly fire drills, some residents do not evacuate to a designated meeting place away from the building or within the fire safe area. Instead, they stay in their rooms when their hallway is not affected by the fire.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

Residents shall be evacuated to designated meeting place (main dining room) on both floors, If main dining room is compromised, residents from each hall would proceed to the den at the end of each corridor behind the fire doors. If residents need to be evacuated away from the building, the meeting place would be outdoor main courtyard where

132h - Designated Meeting Place (continued)

they can proceed through the gate. Director of Plant Operations will be in-serviced by Fire and Safety Solutions by 06/22/2023 on these meeting places to train staff. Future fire drills will reflect these changes to designated evacuation meeting place on each floor. Fire and Life Safety Solutions will complete fire drills and director of plant operations will be responsible for over sight of each step.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented (- 06/28/2023)

141a 1-10 Medical Evaluation Information

10. 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 #1's medical evaluation dated /2023 did not include (7) The ability to Self-Administer Medications.
Resident #2's medical evaluation dated 2023 did not include (9) Health Status/Cognitive Functioning.

Plan of Correction ***Accept (- 05/30/2023)***

Medical Evaluation was immediately corrected for resident #1 and resident #2. In-service was completed for Director Of Nursing on 05/16/2023 by Administrator. Reviewed regulation 26.00141(a). All DME' s have been reviewed by DON and Administrator to ensure they are correct and present in residents chart.
Please see attached exhibit F
Please see attached corrected DME
Please see attached Exhibit C

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented (- 06/28/2023)

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

Resident #2's annual DME was completed on 2022. The resident's previous medical evaluation was completed on /2021.

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction ***Accept (CM - 05/30/2023)***

Inservice was completed with Director Of Nursing by administrator. Reviewed regulation 2600.14(b) Completed review 05/16/2023. Audits will be completed Quarterly by DON to ensure DME form is correct and in residents file.

Please see attached exhibit C
Please see attached exhibit F

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented ([redacted] - 06/28/2023)

181d -Storing Medication

12. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #1 self-administers medications and stores medications in his/her room. On 05/09/2023, the resident said that he/she kept the medications in an unlocked drawer in the living room and that he/she did not always lock the door when going out.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

Resident was given a metal lock box to store medications on 5/10/23 by Administrator. Medications are secured in locked box. All residents that self administer have been educated by administrator on 05/23/23. Resident #1 verbalized that [redacted] will lock [redacted] door when leaving [redacted] apartment. Resident #1 was educated by Administrator on Personal Care medication requirements on 05/10/2023. Nursing supervisors conduct medication administration reviews Q 6 months for all residents that self administer.
Please see attached Medication admin safety screen

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented ([redacted] - 06/28/2023)

185a - Implement Storage Procedures

13. 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 05/09/2023, resident #3's glucometer was not calibrated to correct time. The glucometer displayed 08:48 AM at 12:00 PM.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

We have 2 Glucometers. Both Glucometers were immediately replaced with new ones by Administrator. Weekly audits are completed by nursing supervisor beginning on 5/09/23. Administrator and DON are responsible for ensuring audits are completed.
Please see attached Exhibit D

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented (- 06/28/2023)

224a Preadmission Screen Form

14. 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 #2 was admitted to the home on 2021; however, the resident's preadmission screening form was completed on /2021.

Plan of Correction ***Accept (- 05/30/2023)***

This Violation is from previous administration.

Current administration has read and understands regulation 2600.224(a). Administrator is responsible for completing paperwork. On 05/24/23 Administrator has reviewed and completed move in checklist to prevent iolation from recurring.
Please see attached pre admission checklist

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented (- 06/28/2023)

15. 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 #4's preadmission screening form, dated /2022, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept (- 05/30/2023)***

This Violation is from previous administration. This paperwork was corrected on 5/24/23 by administrator.

Current administration has read and understands regulation 2600.224(a) on 05/24/23 Administrator has reviewed and is using move in check list to prevent this from recurring. On 5/24/23 The pre admission screening was updated to reflect that the needs of the resident can be met by the home by administrator.
Please see attached move in checklist

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented (- 06/28/2023)