

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

October 2, 2023

[REDACTED]
MEADOWOOD CORPORATION
P.O.BOX 670, 3205 SKIPPACK PIKE
WORCESTER, PA, 19490

RE: MEADOWOOD
P.O.BOX 670, 3205 SKIPPACK PIKE
WORCESTER, PA, 19490
LICENSE/COC#: 12787

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/18/2023, 07/19/2023 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: MEADOWOOD License #: 12787 License Expiration: 10/29/2023
Address: P.O.BOX 670, 3205 SKIPPACK PIKE, WORCESTER, PA 19490
County: MONTGOMERY Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: 6105841000 Email: [REDACTED]

Legal Entity

Name: MEADOWOOD CORPORATION
Address: P.O.BOX 670, 3205 SKIPPACK PIKE, WORCESTER, PA, 19490
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-1 Date: 10/20/1988 Issued By: L&I
Type: I-2 Date: 07/29/2022 Issued By: Worcester Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 77 Waking Staff: 58

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 07/19/2023

Inspection Dates and Department Representative

07/18/2023 - On-Site: [REDACTED]
07/19/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity: 76	Residents Served: 52		
Secured Dementia Care Unit			
In Home: Yes	Area: McLean	Capacity: 22	Residents Served: 16
Hospice			
Current Residents: 7			
Number of Residents Who:			
Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 52		
Diagnosed with Mental Illness: 6	Diagnosed with Intellectual Disability: 0		
Have Mobility Need: 25	Have Physical Disability: 0		

Inspections / Reviews

07/18/2023 - Full
Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/11/2023

Inspections / Reviews (*continued*)

08/28/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 09/29/2023
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/02/2023

09/13/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 09/29/2023
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 09/30/2023

10/02/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: 09/29/2023
Reviewer: [REDACTED] Follow-Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 07/18/2023, a copy of chapter 2600 was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept (████ - 09/13/2023)

2600 booklet placed in hallway wall folder with 2022 survey on 7/18/23 by PCHA. Observation of presence will be checked weekly during weekly rounds and documented on tracking sheet that began 8/4/23 and will continue through 9/30/23 with weekly checks thereafter by PCHA/designee. PCHA/designee will report placement at QAPI meetings.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented (████ - 10/02/2023)

15a - Resident Abuse Report

2. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 04/13/2023 at 10:35 PM, resident #1 wandered into resident #2's room. Resident #2 reported to a caregiver that resident #1 had slapped the resident on the face when asked to get out. On 06/20/2023 at 09:00 PM, resident #1 wandered into another resident's room and when told to leave, resident #1 slapped the other resident on the right arm. However, these allegations of abuse were not reported to the local Area Agency on Aging.

Plan of Correction

Accept (████ - 09/13/2023)

PCHA reported to █████ at AAA and faxed reports on 9/11/23, see attached. Reports will be completed within the regulated time period by the PCHA/designee. Any future reports will be submitted to BOTH the Department and AAA. PCHA or designee will report incidents at QAPI meetings for compliance. Attachment shows both agencies were contacted for recent incident within the regulated time period.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented (████ - 10/02/2023)

65g - Annual Training Content

3. 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:

Description of Violation

Staff person A did not receive training in the following topics in 2022.

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.

65g - Annual Training Content (continued)

- 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
- 5. Falls and accident prevention.

Plan of Correction

Accept (█) - 09/13/2023

Staff person A completed the Annual training on fire safety, emergency preparedness- and falls/accident prevention. Audit of 2022 completed by Director of Quality August 24, 2023 and 2023 audit in process. Staff identified who were out of compliance in 2022 completed the required sessions, see attached. Review in November of all staff by their manager for completion of regulatory trainings. Outstanding 2022 findings will be completed by September 12. Process will continue annually by department managers. PCHA/designee will report audit of annual training completion at QAPI meetings.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented (█) - 10/02/2023

82c - Locking Poisonous Materials

4. 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 07/19/2023 at 12:10 PM, a large bottle of Listerine, with a manufacture's label indicating "If more than used for rinsing is accidentally swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept (█) - 09/13/2023

McLean employees educated on regulation 82C. Materials with caution labels will be locked away when not in use. PCHA/designee will check for locked items during weekly rounds starting 8/4/23 and track on rounding sheet and moving forward each week by PCHA/designee. PCHA/designee will report to QAPI meetings for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented (█) - 10/02/2023

91 - Telephone Numbers

5. Requirements

- 2600.
- 91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room #184.

91 - Telephone Numbers (*continued*)**Plan of Correction**

Accept [REDACTED] - 09/13/2023)

Emergency telephone list placed on 7/18/23 on room 184 bedside table and rounding began 8/4/23 and will continue weekly thereafter by PCHA/designee. All other rooms checked had a telephone list in place. Emergency phone list added to move-in checklist. Weekly rounding will confirm placement of emergency telephone lists. PCHA/designee will report to QAPI for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented [REDACTED] - 10/02/2023)

96a - First Aid Kit

6. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the van does not include antiseptic, adhesive bandages, eye coverings, and tweezers.

Plan of Correction

Accept [REDACTED] - 09/13/2023)

First aid kit on the Resident bus was updated with identified items and transportation employees educated on 96a. Items will be updated after use and checked monthly for compliance by the Transportation Supervisor/designee. Missing items were placed on 8/4/23 by Transportation Supervisor and will be checked monthly by Transportation Supervisor/designee. PCHA/designee will report to QAPI for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented [REDACTED] - 10/02/2023)

103f - Refrigerator/Freezer Temps

7. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 07/19/2023 at 10:55 AM, the temperature in the ice cream freezer in the main kitchen was 10 degrees Fahrenheit.

Plan of Correction

Accept [REDACTED] - 09/13/2023)

Daily checklists show the ice cream freezer is at 0 degrees compliance. See attached. Temperatures are checked 2x per day by dining employees for compliance beginning monthly 8/1/23 and daily moving forward. Dining Director/designee will report to QAPI for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented [REDACTED] - 10/02/2023)

103g - Storing Food

8. Requirements

2600.

103.g. Food shall be stored in closed or sealed containers.

103g - Storing Food (continued)

Description of Violation

In the ice cream freezer in the main kitchen, there were two containers of ice cream which were opened and uncovered.

Plan of Correction

Accept (████) - 09/13/2023)

Plastic lids were purchased to cover ice cream containers and placed 8/7/23 by Dining Director. Dining staff educated on 103g by Dining Director 8/7/23. Ice cream covering tracking sheet attached. Tracking began September 1 by dining employees and will be overseen by Dining Director. Tracking will continue monthly. Dining Director/designee will report to QAPI for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented (████) - 10/02/2023)

184a - Resident's Meds Labeled

9. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for resident #3's Dextromethorphan Ex release cough syrup reads 'give 5 mg by mouth twice a day for cough for 5 days' while current order says every 24 hours as needed. There is no direction change sticker on the box.

Plan of Correction

Accept (████) - 09/13/2023)

Change of direction sticker replaced on the cough medicine box. Weekly rounding began 8/4/23 by PCHA to assure medication orders that have been changed have a change of direction sticker securely placed. Sign off sheet weekly to show compliance x3 months and then monthly x 6 months by PCHA/Nurse. PCHA/designee will report to QAPI for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented (████) - 10/02/2023)

187b - Date/Time of Medication Admin.

10. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed Oxandrolone 2.5 mg twice a day. According to the controlled substance record, this medication was signed out and administered on 07/04/2023 at 06:00 PM but the resident's July medication administration record (MAR) does not include the initials of the staff person who administered it. The same medication was not signed out on 07/06 at 08:00 AM, 07/09 at 08:00 AM, and 07/13 at 04:00 PM but staff initials are present.

Resident #5 is prescribed Clonazepam 0.5 mg once daily at bedtime. According to the controlled substance record, it was not signed out and not administered on 07/12/2023 and 07/13/2023. However, there is staff initials present on the resident's July MAR.

Plan of Correction

Accept (████) 09/13/2023)

Audit of scheduled controlled substance log and MAR for residents receiving controlled substance medications

187b - Date/Time of Medication Admin. (continued)

performed by the Staff Educator on 8/7. Staff involved in the two violations received education for controlled substance documentation by Staff Educator on 8/9/23. Audit tool developed by Staff Educator for EMAR/Narc sheet for Personal Care. Audit will be performed weekly x 1 month beginning 9/10/23, then bi-weekly x 2 months, then 1x monthly x 3 months by Staff educator/designee. PCHA/designee will report at QAPI for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented [redacted] 10/02/2023)

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

Resident #4 is prescribed Oxandrolone 2.5 mg twice a day. According to the controlled substance record, this medication was not signed out and not administered on 07/06 at 08:00 AM, 07/09 at 08:00 AM, and 07/13 at 06:00 PM.

Resident #5 is prescribed Clonazepam 0.5 mg once daily at bedtime. According to the controlled substance record, it was not signed out and not administered on 07/12/2023 and 07/13/2023.

Plan of Correction

Accept [redacted] 09/13/2023)

Audit of scheduled controlled substance log and MAR for residents receiving controlled substance medications performed by Staff educator on 8/7/23. Staff involved in the two violations received education for controlled substance documentation by staff educator on 8/9/23 and will receive a competency check with staff developer/designee. Audit will be performed weekly x 1 month beginning 9/10/23, then bi-weekly x 2 months, then 1x monthly x 3 months by Staff educator/designee. PCHA/designee will report at QAPI for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented [redacted] - 10/02/2023)

251b - Record Entries Legible

12. Requirements

2600. 251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident #4 is prescribed Oxandrolone 2.5 mg twice a day. On the controlled substance record for this medication, the amount left on entry 1, 3, and 4 was written over, line entry 2 was crossed out without proper notations, and the date on entry 14 was written over.

Plan of Correction

Accept [redacted] - 09/13/2023)

Education to all medication administrators conducted on documentation of controlled substance record held on 8/4/23 by Staff Educator. Weekly checks will be conducted by PCHA/designee for compliance beginning 8/4/23 and weekly moving forward. PCHA/designee will report at QAPI meeting for compliance or re-evaluation.

Licensee's Proposed Overall Completion Date: 08/30/2023

251b - Record Entries Legible (*continued*)

Implemented ([REDACTED] - 10/02/2023)