

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

November 9, 2023

[REDACTED], RDO  
RAPPS SENIOR CARE LLC

RE: WOODBRIDGE PLACE  
1191 RAPPS DAM ROAD  
PHOENIXVILLE, PA, 19460  
LICENSE/COC#: 14359

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/27/2023 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: WOODBRIDGE PLACE License #: 14359 License Expiration: 11/23/2023  
 Address: 1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460  
 County: CHESTER Region: SOUTHEAST

## Administrator

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

## Legal Entity

Name: RAPPS SENIOR CARE LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

## Certificate(s) of Occupancy

Type: C-2 LP Date: 07/01/1996 Issued By: CWOPA L&I

## Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 79 Waking Staff: 59

## Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Incident, Monitoring Exit Conference Date: 07/27/2023

## Inspection Dates and Department Representative

07/27/2023 - On-Site: [REDACTED]

## Resident Demographic Data as of Inspection Dates

## General Information

License Capacity: 125 Residents Served: 54

## Secured Dementia Care Unit

In Home: Yes Area: SDCU Capacity: 21 Residents Served: 16

## Hospice

Current Residents: 4

## Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 53  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 25 Have Physical Disability: 0

## Inspections / Reviews

07/27/2023 Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/31/2023

09/01/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 10/20/2023  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/06/2023

Inspections / Reviews (*continued*)

09/05/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/20/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/05/2023

10/11/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/20/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/15/2023

11/09/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/20/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan dated [redacted] for resident #1 indicates the resident requires total physical assistance with toileting and bowel and bladder management. On [redacted] at [redacted], staff person A, who was assigned to care for resident #1, was informed that resident had been incontinent and needed to be changed. Staff person A did not provide the needed care to resident #1 and instead left the floor to take a break. At 1pm the same day, resident #1 was observed to be refusing to sit down. When checked, it was discovered that resident had not been changed and had dried fecal matter on them making it uncomfortable for the resident to sit down.

Plan of Correction

Accept [redacted] - 09/01/2023)

When: Community staff member reported on July 10th to Director of Wellness that Staff Member A did not attend to resident #1 needs on July 8th. The Director of Wellness and Executive Director immediately investigated the situation and staff member A was suspended pending completion of the investigation. Staff member A was terminated. Community self-reported incident to Department of Human Services on July 10th. This visit was a result of that self-report.

Who: All staff members were re-educated on August 23rd by the Director of Wellness and Executive Director regarding Activities of Daily Living and resident's individualized service plans.

How: Memory Care director to conduct random ADLs checks twice weekly for twelve weeks beginning August 28th. Quality Assurance committee to review results of checks monthly for three months and make recommendations if appropriate.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [redacted] - 11/09/2023)

42c - Treatment of Residents

2. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

The home attempted to seat the residents for lunch in the dining room on [redacted] at [redacted]. Staff person B and C overheard staff member A yelling at resident #2 to "sit the hell down" loudly. Staff member A shouted at the resident "get out of my face". Resident #2 was having an anxiety attack. When staff members B and C overheard staff member A employing the tone, intervened. They diverted attention away from staff member A and took over the care of resident #2.

Around [redacted] staff member B had informed staff member A that resident#1 needed to be changed because resident#1 was soiled. Staff member A refused by saying they were going to lunch and did not provide care

**42c Treatment of Residents (continued)**

to resident #1. Resident #1's support plan dated [REDACTED], indicates resident requires total physical assistance with toileting and bladder and bowel management. At 1pm on [REDACTED], staff member C noticed resident #1 was refusing to sit down. Staff member C checked the brief of resident #1, at which time they observed dried fecal matter on the resident and in the incontinence brief which was making it difficult or uncomfortable for the resident to sit down.

**Plan of Correction**

Accept ([REDACTED] - 09/01/2023)

*When:* On July 10th, it was reported by community staff member to Director of Wellness that Staff Member A did not treat resident #2 with dignity and respect on July 8th. The Executive Director immediately investigated the situation and staff member A was suspended pending completion of the investigation. Staff member A was terminated. Community self reported incident to Department of Health Services on July 10th. This visit was a result of that self report.

*Who:* All staff members were re educated on Residents Rights with the emphasis on respect and dignity on August 23rd by Executive Director. Training will be repeated during the staff meeting on September 27th. Executive Director to conduct the training.

*How:* Memory Care director to conduct random interviews with staff and residents in memory care regarding dignity and respect twice weekly for twelve weeks beginning August 28th. Quality Assurance committee to review results of checks monthly for three months and make recommendations if appropriate

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented ([REDACTED] - 11/09/2023)

**101i - Access to Bedroom****3. Requirements**

2600.

101.i. A resident shall have access to his bedroom at all times.

**Description of Violation**

On [REDACTED] at [REDACTED], residents in the memory care unit were denied access to his/her bedroom by staff member A. According to staff interviews, staff member A would lock resident bedroom doors after residents exited their rooms, to prevent them from stealing from entering each others rooms. Staff member C witnessed staff member A locking the doors of the resident's rooms that they were assigned to.

**Plan of Correction**

Accept ([REDACTED] - 09/05/2023)

*When:* On July 10th, it was reported by community staff member to the Director of Wellness that staff member A was locking resident apartment doors and residents were not able to enter. Executive Director immediately investigated the situation, and staff member A was suspended pending completion of investigation. Staff member A was terminated. Community self reported incident to Department of Health Services on July 8th. This visit was a result of that self report.

*Who:* All staff members were re educated on Residents Rights with the emphasis on respect and dignity. Training took place during the monthly staff meeting on August 23rd. Training will be repeated during the staff meeting on September 27th.

*How:* Memory Care Director to conduct random interviews with staff and residents in memory care regarding dignity and respect twice a week for twelve weeks. Memory Care Director or designee starting September 1st for next 12

101i - Access to Bedroom (continued)

weeks to periodically check that none of the bedrooms are locked in memory care. Quality Assurance committee to review results of checks monthly for three months and make recommendations, if appropriate.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented (████) - 11/09/2023)

183e - Storing Medications

4. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On █████, residentt#3's █████, was open and in the medication cart without an opened on date. According to the manufacturer's instructions medication needs to be discarded after 28 days.

Plan of Correction

Accept (████) - 09/01/2023)

When: The sticker with the date when █████ was opened was placed immediately on the medicine while inspector was still in the facility.

Who: Medication administration training for Med-Techs and LPNs was held on August 23rd by the Director of Wellness regarding dating insulin when opened.

How: Weekly medication cart audits to be completed by Wellness Director or designee beginning August 23rd for the twelve weeks, and reviewed by Quality Assurance committee monthly.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (████) - 10/11/2023)