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

August 15, 2023

[redacted], EXECUTIVE DIRECTOR
THE HICKMAN FRIENDS SENIOR COMMUNITY OF WEST CHESTER
400 NORTH WALNUT STREET
WEST CHESTER, PA, 19380

RE: THE HICKMAN
400 N. WALNUT STREET
WEST CHESTER, PA, 19380
LICENSE/COC#: 14093

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/28/2023, 06/29/2023 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 HICKMAN* **Licen e #**: *14093* **Licen e Expiration**: *03/13/2024*

Address: *400 N. WALNUT STREET, WEST CHESTER, PA 19380*

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

Administrator

Name: *Toni* **Phone**: *Kelly* **Email**: *tkelly@thehickman org*

Legal Entity

Name: *THE HICKMAN FRIENDS SENIOR COMMUNITY OF WEST CHESTER*

Address: *400 NORTH WALNUT STREET, WEST CHESTER, PA, 19380*

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

Certificate(s) of Occupancy

Type: *I 1* **Date**: *01/28/2018* **I ued By**: *Borough of West Chester*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *116* **Waking Staff**: *87*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *06/29/2023*

Inspection Dates and Department Representative

06/28/2023 On Site [redacted]

06/29/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *74*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Darlington* **Capacity**: *26* **Residents Served**: *20*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *74*

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

Have Mobility Need: *42* **Have Physical Disability**: *42*

Inspections / Reviews

06/28/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/23/2023*

07/25/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/30/2023*

Inspections / Reviews *(continued)*

07/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/30/2023*

08/15/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2023*

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

42s - Privacy

1. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 06/28/23 at 10:00 am, cameras were observed throughout the facility. The cameras record video only. The home does not have any postings or signs indicating that images are being recorded near any of the cameras in use.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

There has been signage posted at each entryway of the facility since camera installation. As of 7/25/2023 signs have additionally been added to each unit to assure that all residents, visitors and staff are aware. This is also indicated in the Resident Contract. To ensure continued compliance, The Director of Facilities or designee will monitor signage daily with daily rounding.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented [redacted] - 08/15/2023)

65e - 12 Hours Annual Training

2. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A received only 8.25 hours of annual training in training year 2022.

Plan of Correction ***Accept ([redacted] - 07/30/2023)***

On receipt of this POC an audit was initiated to review each employees training record to ensure compliance with the regulation. The HR Manager will have an audit of all files completed by 8/15/2023 and create a tracking list for all employees of all departments. Quarterly audits will take place in September, December, March & June to ensure continual compliance with 65e.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented ([redacted] - 08/15/2023)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

65f - Training Topics *(continued)*

7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2022.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

This employee has received training on 65f in 2023. On receipt of this POC an audit was initiated to review each employees training record to ensure compliance with the regulation. The HR Manager will create a tracking list for all employees of all departments by 8/31/2023 and audit records quarterly in September, December, March & June to ensure continual compliance.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 08/15/2023)

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.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2022 to 2023.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

This employee has received training on 65g as of the date of this POC. On receipt of this POC an audit was initiated to review each employees training record to ensure compliance with the regulation. The HR Manager will create a tracking list for all employees of all departments by 8/31/2023. The HR Manager will audit records quarterly in September, December, March, June to ensure continual compliance with 65g.

Licensee's Proposed Overall Completion Date: *08/15/2023*

65g - Annual Training Content *(continued)*

Implemented (MS 08/15/2023)

100a - Exterior - Free of Hazards

5. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

on 6/28/23 multiple kitchen mats were piled on the ground, outside on the grass near the walkway that leads to the dumpster of The Hickman Building.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

The mats have been discarded as of the date of this POC. An environmental checklist including exterior grounds will be completed to indicate the date, time and staff person that completed the check weekly. This will be completed by the Dining Director or designee. The checklist was initiated on 7/26/2023

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented ([redacted] 08/15/2023)

103e - Left Overs

6. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated bag of sausage in the walking freezer.

Plan of Correction ***Accept ([redacted] - 07/30/2023)***

his food item was immediately discarded. All dining service staff have been provided in service training around specific protocols for of labeling and dating to prevent reoccurrence. These trainings took place on 7/3/2023 & /4/2023. An environmental checklist has been created to include the refrigerators and freezers which will indicate the date, time and staff person that completed the check. This audit was started on 7/26/23 and will be performed weekly by the Dining Director or designee.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented ([redacted] - 08/15/2023)

103i - Outdated Food

7. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was a turkey bag mix with a date of 09/01/22, and a tray of twelve small pizzas with a date of 02/03/22 in the walk in fridge in the kitchen.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

hese food items were immediately discarded. On 7/3/23 & 7/4/2023 all dining service staff have been provided

103i - Outdated Food (continued)

n-service training around specific protocols for of labeling, dating and disposal to prevent reoccurrence. An environmental checklist has been created to include the refrigerators and freezers which will indicate the date, time and staff person that completed the check. This audit has been initiate as of 7/26/2023 and will be performed weekly by the Dining Director or designee.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented [redacted] - 08/15/2023)

105g - Lint Removal and Duct Cleaning

8. 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 06/28/23, there was an accumulation of lint in the lint trap of the second floor dryer in The Hickman Building. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

All Housekeeping staff were in-serviced on 7/21/23 & 7/25/23 to the importance and protocol. An internal checklist to indicate date, time and staff person that completed the routine dryer check has been implemented as of 7/21/2023. The Housekeeping Supervisor or designee will complete the routine checks weekly to ensure ongoing compliance with 105.g. The long vents to each dryer are professionally maintained quarterly.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented [redacted] - 08/15/2023)

132g - Fire Drills Days/Times

9. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills in the last seven days or the last week of the month as evidenced by the following drills 02/22/23 at 10:14am, 03/23/23 at 7:09pm, 04/28/23 at 4:02 am, 05/23/23 and 06/23/23 at 3:05pm.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

The Annual Fire Drill schedule was altered to reflect more sporadic dates throughout each month. Training to the schedule and overall clarification of the process was completed on 7/25/2023 with the Maintenance/Security Team. The Director of Maintenance will assure continued compliance with 132.g

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented [redacted] - 08/15/2023)

141a 1-10 Medical Evaluation Information

10. Requirements

141a 1-10 Medical Evaluation Information *(continued)*

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 [redacted]/23, did not include the resident's medical diagnoses.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

The Medical evaluation was updated with diagnosis by the Resident Services Director after review with the PCP on 7/20/2023. An internal audit has been initiated by the Care Mangers of current DME's and will be completed by 8/5/2023. Training was provided to the Care Managers and Admission Specialist on 7/26/2023 to re-inform of DME requirements and new admission check list put into place. Many physicians fail to complete the form in its entirety or attach progress digital notes. The Admissions specialist will review for completion at time of receipt. A new admission Checklist will be completed by the Care Managers upon each new admission and if incomplete, the Director of Resident Services will contact the physician to remedy.

Licensee's Proposed Overall Completion Date: *08/05/2023*

Implemented [redacted] - 08/15/2023)

183d - Prescription Current

11. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 01/30/23, the home received a discontinue order for resident#2's [redacted]. The medication remained on the medication cart through 5/11/23.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

All Medication technicians have been in-serviced to Regulation 2600.183(a),(b), (c),(d),(e),(f),&(g). on 6/30/2023.The Director of Resident Services or designee will perform a weekly med cart audit which began on 7/3/2023 to ensure ongoing compliance with regulation 183. These weekly audits will continue indefinitely as a continuous quality metric.

Licensee's Proposed Overall Completion Date: *07/28/2023*

[redacted] - 08/15/2023)

183f - Discontinued Medications

12. 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

The following medication: Tramadol HCL 50mg, belonging to resident #2 was discontinued on 1/30/2023. The medication was not removed from the medication cart and the medication continued to be administered to the resident on multiple dates from 2/2/23 through 5/11/23.

Plan of Correction ***Accept (MS - 07/30/2023)***

On 6/30/2023, all Medication technicians were in-serviced to Regulation 2600.183(a),(b), (c),(d),(e),(f),&(g). The Director of Resident Services or designee will perform a weekly med cart audit to ensure ongoing compliance with regulation 183. These audits began on 7/3/2023 and will continue indefinitely as a continuous quality metric.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented ([redacted] - 08/15/2023)

187a - Medication Record

13. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #3 is prescribed [redacted] tabs take one tablet by mouth every 4 hours as needed. This medication was administered on [redacted] however, it is not included on resident #3's medication administration record for Jan 2023 and Feb 2023

Plan of Correction ***Accept ([redacted] - 07/30/2023)***

All Medication technicians have been in-serviced to Regulation 187.a. This took place on 6/30/2023. The Director of Resident Services or designee will perform a weekly med cart audit and monthly med review to ensure ongoing compliance with regulation 187. The weekly audits started on 7/3/2023 and will continue indefinitely as a continuous quality metric. The monthly medication reviews will be completed in the last week of each month and provided to physicians for signing. This will begin in the month of August.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented ([redacted] - 08/15/2023)

187b - Date/Time of Medication Admin.

14. 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 #2 was prescribed a new order on 5/18/2023 for [redacted], take 1 tablet by mouth every 8 hours as needed for pain. Resident #2

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

's medication administration record does not include the initials of the staff person who administered [redacted] mg on 05/26/23 at 5pm.

Plan of Correction ***Accept ([redacted] - 07/30/2023)***

All Medication Technicians were in-serviced to regulation [redacted] on 6/30/2023. The Director of Resident Services or designee will perform a weekly audit of MAR's indicating date, time and signature to ensure ongoing compliance with cited regulation. This audit began on 7/3/2023 and will continue indefinitely as a continuous quality metric.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented [redacted] - 08/15/2023)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident #2's order for [redacted], take one tablet as needed for pain, was discontinued on 1/30/2023. However, resident #2 was administered [redacted] on multiple dates through the months of February, March, April, and up to May 11, 2023 as evidenced by residents narcotics inventory log.

Plan of Correction ***Accept ([redacted] - 07/30/2023)***

All Medication technicians were in-serviced to Regulation 187.a on 6/30/2023. The Director of Resident Services or designee will perform a weekly med cart audit and monthly med review as evidenced by signature, date and time of person completing the audit to ensure ongoing compliance with regulation 187. The audit began on 7/3/2023 and will continue indefinitely as a continuous quality metric.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented (MS - 08/15/2023)

188b - Medication Error Reporting

16. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #2's order for [redacted], take one tablet as needed for pain was discontinued on 1/30/2023. However, resident #2 was administered [redacted] on multiple dates through the months of February, March, April, and May 2023. The medication error was not reported to the resident, resident's designated person, prescriber.

Plan of Correction ***Accept ([redacted] - 07/30/2023)***

All Medication Technicians, Personal Care Coordinators and the Director of Resident Services were in-serviced to regulation 188 b on 6/30/2023. The Director of Resident Services or designee will perform weekly med cart audits, weekly MAR review as evidenced by a document indicating date, time and person completing the form. The weekly audits have begun as of 7/3/2023 and will be indefinite as a continuous quality metric. The monthly medication reviews will begin on 8/1/2023.

188b - Medication Error Reporting *(continued)*

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented [redacted] - 08/15/2023)

191 Resident Right to Refuse

17. 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.

Description of Violation

Resident #1, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #4, admitted [redacted] 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 ([redacted] 07/25/2023)***

This verbiage was added immediately upon discovery by the inspector to the Resident Contract under "Resident Rights". This contract is reviewed and signed by each resident prior to admission. A new Resident Rights Memo nclusive of regulation 191 will be signed by each current resident and placed in their file. The Administrator will ensure completion by all residents by 7/31/2023.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented ([redacted] - 08/15/2023)

227d - Support Plan Medical/Dental

18. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #2, dated [redacted] indicates the resident is a high fall risk. The resident's support plan dated [redacted] does not document how this need will be met.

Plan of Correction ***Accept ([redacted] 07/30/2023)***

A review of falls and interventions is completed weekly for each resident at the interdisciplinary meeting. An In-service was completed for each Personal Care Coordinator on regulation 2600.227.d. on 7/12/2023. An audit of each resident identified as a "fall risk" has been initiated and will be completed by 8/1/2023. The Director of Resident Services will perform an audit of each RASP quarterly to ensure compliance with 227.d. The first audit will be done by 8/1/2023 and quarterly thereafter in Nov, Feb, May and Sept.

Licensee's Proposed Overall Completion Date: *08/01/2023*

Implemented ([redacted] 08/15/2023)

227h - Support Plan Refuse Sign

19. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident#2 participated in the development of his/her support plan on [redacted]/23. The resident was unable to sign the support plan. The home did not make a notation regarding the resident's inability to sign.

Plan of Correction ***Accept [redacted] - 07/30/2023)***

An In-service was completed for each Personal Care Coordinator on regulation 2600.227.h was completed on 7/12/2023. An audit of each RASP under their purview has been initiated. The Director of Resident Services will perform an audit of each RASP quarterly to ensure compliance with 227.h ongoing. The first audit will be completed on 8/1/2023 and quarterly thereafter in Nov, Feb, May and Sept.

Licensee's Proposed Overall Completion Date: *08/01/2023*

Implemented [redacted] - 08/15/2023)

236 - Staff Training

20. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had only .25 hours of training in dementia care during the 2022 training year.

Plan of Correction ***Accept ([redacted] - 07/30/2023)***

On receipt of this POC an audit was initiated to review each employees training record to ensure compliance with the regulation. The audit will be completed by 8/15/2023. The HR Manager will create a tracking list for all employees of all departments and audit records quarterly to ensure continual compliance with regulation 236. The Quarterly audits will take place in September, December, March and June.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 08/15/2023)